STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

CERTIFICATE OF MEDICAL NECESSITY
HEARING AIDS

NAME: _____ MID: _____

DOB: _____

Does beneficiary own any other hearing aids?_____Yes_____No If yes, how many?_____

If yes, what is the age of the hearing aid(s)? Hearing Aid #1_____Hearing Aid #2 _____

Were the hearing aid(s) purchased through Medicaid?_____Yes _____No

Describe the hearing aid(s) _____

_____

Why is the beneficiary requesting new hearing aid(s)? _____

_____

This is to certify that an otological examination of the above-named beneficiary demonstrates a hearing impairment of such a nature as to indicate the need for a hearing aid instrument or hearing prosthetic device.

Prescriber Signature:_____MD/DO

Prescriber Name: _____
Please print or type

NPI: _____

Date: _____

Proof of medical necessity is valid for 12 months from the date of issue.