Must return to office

LIONS OF ILLINOIS FOUNDATION SOCIAL SERVICES DEPARTMENT
RECONDITIONED HEARING AID APPROVAL FORM
2814 Dekalb Ave., Sycamore, IL 60178; **FAX: 815/748-9087**

Please print or type: DATE:_____

Name of Patient: _____
Address:_____
City:_____ State:_____ Zip:_____
Home PH: _____ Work PH:_____
Date of Birth_____

Check for full amount must accompany request or paperwork will not be processed

Amount due for this referral $_____

Please indicate below, the services that your club will provide

MEDICAL CLEARANCE

____Our club will pay the cost of the medical clearance_____
____Medical clearance is enclosed.
____Client may waive medical clearance.

CLINIC PROFESSIONAL/VISIT FEE (if applicable)

____Our club will pay fee_____.

HEARING EVALUATION

___Our club will pay the cost of the audiogram._____.

___Audiogram is enclosed (**If you already have current audio, subtract amount from total) must be dated w/in last 5 months**

EARMOLD IMPRESSION

___ Our club will pay for cost of 1 or 2 ear mold impression(s)_____.

FITTING AND SELECTION

___Our club will pay the cost of the fitting and selection for 1 or binaural hearing aids_____.

USED HEARING AID DISTRIBUTION--*CLINIC TO BE USED:* _____

___ Our club will pay for a reconditioned hearing aid as recommended by the clinic. $175.00
___ Our club will pay for a programmable hearing aid if recommended by audiologist (extra $50.00)
___ Our club will pay for binaural hearing aids (2 aids) and additional mold and fitting.

___ **HEARING AID REPAIR** _____ ___ **POCKET TALKER** _____

CLUB NAME:_____DISTRICT_____
. CLUB REPRESENTATIVE: _____
ADDRESS:_____
CITY:_____STATE:._____ ZIP_____
HOME PH:_____ WORK PH:_____
FAX NO._____ Email:_____