



**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
MEDICAID PROGRAM  
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES**

**CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION  
HEARING AIDS**

\_\_\_\_\_  
Name MID

\_\_\_\_\_  
Street Address City/State/Zip Date of Birth

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.

Signed: \_\_\_\_\_ MD/DO

Name: \_\_\_\_\_

*Please print or type*

NPI: \_\_\_\_\_

Date: \_\_\_\_\_ Address: \_\_\_\_\_