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

Date: _____ Address: _____