**BIGSTONE HEALTH COMMISSION**

Bigstone Health Benefits Medical Supplies and Equipment
Audiology Prior Approval Form

BIGSTONE HEALTH COMMISSION
PROTECTED WHEN COMPLETED

**Section 1: Client Information**

| | | |
|---|---|---|
| Client Name: | | Date of Birth: |
| Client Address: | | |
| Telephone #: | PHN #: | Client ID #: |

**Section 2: Prescriber Information**

| | |
|---|---|
| Prescriber Name: | License #: |
| Telephone #: | Fax #: |

**Section 3: Client Health Information (MUST BE COMPLETED)**

Diagnosis: Reason for request:

Explanation of benefit requirement and specific details of item to be provided:

Date of most recent audiometric test:

Is the benefit requested due to the result of an injury: YES ☐ NO ☐ If yes, please complete the following:

Where did the injury occur: When did the injury occur?

Home: ☐ Work: ☐ MVA: ☐ Other: ☐ Has the client ever worked in a noisy environment?

Are any of these expenses covered under any other public or private health care plan: Yes ☐ No ☐

**Section 4: Equipment or Supplies requested**

| Description of benefit \| Left or Right \| Manufacturer and Model | Benefit Code | Qty | Cost Per Unit |
|---|---|---|---|
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**Section 5: Provider Information**

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|---|---|
| Provider Name: | Provider Number: |
| Telephone #: | Fax #: |
| I hereby certify that the information is true and complete:<br><br>Provider Signature: | Date: |

| | |
|---|---|
| Bigstone Health Benefits | |
| Office Telephone: (780) 341-2777 | Direct Line: (780) 341-2776 |
| Office Address: 16310 100 Avenue NW Edmonton, AB T5P 4X5 | Office Fax: (780) 444-6521 |

**Submit with the following:**

- **Signed prescription/recommendation**
- **Dated audiometric test (must be less than 6 months old)**
- **Additional information supporting the request for items, if available**
- **For early replacement requests: include reasoning for early replacement and previous audiogram**