Physicians Examination Report

Client Name (Last, First, M)	Client No.	Date of Birth
Address (Street, City, State, Zip Code)		

1. Date of Examination*

2. Ear Examination:

   1. Within Normal Limits
      ❑ Yes ❑ No
   2. Cerumen Removed
      ❑ Yes ❑ No
   3. Describe Ear Abnormalities:

_____

_____

3. Is more otolaryngological examination/treatment required to provide medical clearance for the fitting of a hearing aid? ❑ Yes ❑ No

If yes, refer this patient for consultation and completion of this form.

4. Are there any medical contradictions to hearing aid usage in either ear? ❑ Yes ❑ No

If yes, a hearing aid is medically prohibited in ❑ Right Ear ❑ Left Ear

5. Is the above-named individual a candidate for a hearing aid evaluation? ❑ Yes ❑ No

Signature* -Physician	Physician's Name (please type or print)	Medical Specialty
Address	Telephone No.	

***NOTE PLEASE FURNISH THE PATIENT WITH THE SIGNED AND DATED ORIGINAL AND ONE COPY OF THIS FORM**

To be reimbursed for the examination, you must submit this completed form along with a claim for physician's services to the following address:

Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Suite 100
Austin, TX 78727