



**Lions of Illinois Social Service Department
RECONDITIONED HEARING AID APPROVAL FORM
2254 Oakland Dr., Sycamore, IL 60178: Fax: (815)748-9087**

Date: _____

Name of Patient: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **City:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____

Please indicate below, the services that your club will provide

MEDICAL CLEARANCE

- _____ Client 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 clinic fee \$ _____

HEARING EVALUATION

- _____ Our club will pay the cost of an audiogram \$ _____
- _____ Audiogram is enclosed (If client has test, subtract \$ amount from total) current audiogram must be dated w/in last 6 months.

EARMOLD IMPRESSION (circle either 1 or 2)

_____ Our club will pay for cost of: **1 – 2** ear mold impression(s) \$ _____

FITTING AND SELECTION (circle either 1 or 2)

_____ Our club will pay the cost of the fitting and selection for **1 – 2** hearing aids \$ _____

HEARING AID DISTRIBUTION

- _____ Our club will pay for **1** reconditioned hearing aid as recommended by the clinic. **\$250.00**
- _____ Our club will pay for **2** reconditioned hearing aids as recommended by the clinic. **\$500.00**
- _____ Our club will pay for a programmable hearing aid if recommended by audiologist (extra \$50.00)

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

Amount due for this Referral \$ _____

CLINIC TO BE USED

Club Name: _____ District _____

Club Representative: _____ E-mail: _____

Address: _____ City: _____ Zip _____

Home #: _____ Cell # _____ Work # _____