Lions of Illinois Social Service Department
RECONDITIONED HEARING AID APPROVAL FORM
700 N Peace Rd, Suite B., DeKalb, IL 60115:
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

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

Amount due for this Referral**$**_____

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)

CLINIC TO BE USED

Club Name: _____District_____

Club Representative:_____E-mail:_____

Address:_____City:_____Zip_____

Home #:_____ Cell # _____ Work #_____