Physician's Examination Report

A. Client Information

Client Name (*Last, First, M.I.*):

Client No.:	DOB:

Address:

Number Street Ste. No. City State ZIP Code

B. Examination Information

1. Date of Examination*:

2. Ear Examination:

A. Within Normal Limits ☐ Yes ☐ No

B. Cerumen Removed ☐ Yes ☐ No

C. 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

C. Physician Information

Physician or Delegate Name (*please print*):

Medical Specialty:	Telephone:

Address:

Number Street Ste. No. City State ZIP Code

Signature of Physician or Delegate *(stamped signatures not accepted)*	Date

***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
2357-B Riata Trace Parkway
Suite 100
Austin, TX 78727