



Request for a revalidated service

Client Details

Surname/Family Name

First or Given Name

Eligibility Number

Date of Birth

Privacy and your personal information

Your personal information is protected by law, including the *Privacy Act 1988*. By signing this form you are consenting to and authorising the Department of Health to collect, store and disclose your information, including personal information. You can get more information about the way in which the Department will manage your personal information, including our privacy policy at www.hearingservices.gov.au.

In addition, by signing this form you are indicating you require additional hearing services due to a significant deterioration in your hearing, health or dexterity.

Signature

Date

Relationship of signatory to client[#]

[#]if signing on clients behalf

Provider Details

Provider Trading Name

Provider E-mail

Qualified Practitioners name

Telephone Number

Qualified Practitioner Signature

Date

All areas of the form must be completed prior to submitting, this includes page two and three which indicate the reason for requesting a revalidated service. Please tick only the relevant boxes.

For more information see the webpage on requesting a revalidated service and ensure all supporting documentation is attached when emailing this request.

Please email the completed form and all supporting documentation to hearing@health.gov.au

Reason A – client requires a reassessment

Reason	Required evidence (to be sent with request)	Evidence submitted
A. Significant deterioration in hearing	<ul style="list-style-type: none"> Current audiogram or screening test indicating deterioration in air conduction or bone conduction thresholds of ≥15dB at 2 or more frequencies between 500 to 4000 Hz in at least one ear. Tympanometry results if bone conduction thresholds are not tested to show that the deterioration is not the result of temporary middle ear dysfunction <p>And</p> <ul style="list-style-type: none"> Previous audiogram for comparison 	<input type="checkbox"/> <input type="checkbox"/>
Revalidated service item 800 – Reassessment and 810 (audiological case management if applicable)		<input type="checkbox"/>

Reason B – client meets the Eligibility Criteria for Refitting

Reason	Required evidence (to be sent with request)	Evidence submitted
B. Client is eligible for refitting under the Refitting Requirements and a device fitting has been claimed against the current voucher.	<ul style="list-style-type: none"> Specify which eligibility criteria for refitting the client meets <p>And</p> <ul style="list-style-type: none"> Provide evidence to support this assertion as described in the Eligibility Criteria for Refitting guidelines – note GP letter required if fitting under ECR 2 or 3 	<input type="checkbox"/> <input type="checkbox"/>
Revalidated service item 820 – Refitting and rehabilitation (monaural) or 821 – Refit with no follow up appointment (monaural) 830 – Refitting and rehabilitation (binaural) or 831 – Refit with no follow up appointment (binaural) 825 – Refitting and rehabilitation (ALD) or 826 – Refit ALD with no follow up appointment 760 - Subsequent initial fitting, rehabilitation and maintenance or 761 – Subsequent fitting with no follow up appointment 770 - Subsequent initial fitting, rehabilitation and maintenance or 771 – Subsequent fitting with no follow up appointment		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

(Date of Issue 0219)