



## Request form for a revalidated service

### Client Details

Surname/Family Name

Alpher

First or Given Name

Betty

Voucher Number

123456789X

Date of Birth

01/01/1976

### 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](http://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.

Client Signature

*B. Alpher*

Date

10/08/2019

#POA may only sign on client behalf

n/a

#Power of Attorney

### Provider Details

Provider Trading Name

Can U Hear Me Now

Provider E-mail

[CanUhearMEnow@gmail.com](mailto:CanUhearMEnow@gmail.com)

Qualified Practitioners name

Lysten Closely

Telephone Number

02 1234 5678

Qualified Practitioner Signature

*Lysten Closely*

Date

10/08/2019

### Revalidation services may be requested for two reasons

- [Reason A – the client requires a reassessment, or](#)
- [Reason B – the client requires a refitting and meets the Eligibility for Refitting.](#)

Once a reason (A or B) has been determined, please fill out the form where relevant. To prevent your application being rejected or sent back as incomplete, please ensure that all relevant sections are **legible** and the supporting evidence has been entered on the form and/or attached as requested. **The Request for a revalidated service** form and supporting evidence can be emailed to [hearing@health.gov.au](mailto:hearing@health.gov.au).

For more information see the webpage on [requesting a revalidated service](#).

## Reason B – client meets the Eligibility Criteria for Refitting

Revalidated service item <i>(please select one or more items)</i>		Select
820 – Refitting and rehabilitation (monaural) or 821 – Refit with no follow up appointment (monaural)		<input checked="" type="checkbox"/>
830 – Refitting and rehabilitation (binaural) or 831 – Refit with no follow up appointment (binaural)		<input type="checkbox"/>
825 – Refitting and rehabilitation (ALD) or 826 – Refit ALD with no follow up appointment		<input type="checkbox"/>
760 - Subsequent initial fitting, rehabilitation and maintenance or 761 – Subsequent fitting with no follow up appointment		<input type="checkbox"/>
770 - Subsequent initial fitting, rehabilitation and maintenance or 771 – Subsequent fitting with no follow up appointment		<input checked="" type="checkbox"/>
Reason	Supporting Evidence	Evidence on client file
A. 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"> <li>An Eligibility Criteria for Refitting (ECR) has been met <i>(please select one from the drop down)</i> <b>ECR 3</b></li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>Provide evidence to support this assertion as described in the <a href="#">Eligibility Criteria for Refitting</a> guidelines</li> </ul>	<input checked="" type="checkbox"/>  <input checked="" type="checkbox"/>

## Supporting Evidence for Reason B and ECR 3

(Please type or clearly print in the mandatory free text fields provided)

**ECR 3** - A change in physical condition of the ear or ear health has occurred since last fitting and the client requires a different style of hearing device(s) to accommodate this change.

### Ear health

Describe the change in physical condition of the ear or ear health.

The client had their pinna removed, this has impacted on being able to wear the right BTE device as it no longer sits correctly and keeps falling out.

### Ear surgery

If the client has had ear surgery, please provide the date they had the surgery.

Due to skin cancer of the outer ear, the client had an operation on their right ear in January 2019 to remove the pinna.

### Attempts to resolve issues with current devices

	Y / N
If the client has a custom device, have you tried to re-shell the device?	Yes
Have you tried thin/slim tubes or size 13 tubes?	Yes
Have new mould been taken and tried?	Yes

Describe what has been tried with the current device/s and why they cannot be modified.

We have taken new impression and ordered new moulds. As the pinna was completely removed the device will not sit in the ear and keeps falling out even after attempts to resolve the issue.

### Proposed Solution

	Left	Right	Category 1	Category 2	Category 3	Non-Standard
Proposed device/s	N/A	C321AID	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe what new devices are proposed and how will they address the current issue.

We propose to fit the client with an ITC device for the right ear.

## Doctor's letter

Please attach a **Doctors Letter** that clearly states the change in the physical condition of the ear or ear health and when this change occurred.

Acceptable Letters	<p><b>Example 1</b> – The client had ear surgery on <b>10/01/2019</b> where the pinna was removed and the current aids no longer fit appropriately.</p> <p><b>Example 2</b> – The client has been diagnosed with External Otitis Media on <b>15/01/2019</b> and can no longer wear aids that are in the canal.</p>
Unacceptable Letters	<p><b>Example 1</b> – The client perspires heavily during the warmer months and his current Behind-the-Ear device/s is causing a rash/soreness over the top of his ears.</p> <p><b>Example 2</b> – The client's earlobe has been removed and would like new devices. Could this be organised.</p>

EXAMPLE