Hearing Services Program

Request for Revalidated Service

Part 1 – Applicant Information

1. Client Details

Please provide details.

First or Given Name (Required)

Name

Surname/Family Name (Required)

Surname

Date of Birth (Required)

Day *Month* *Year*

01 - 01 - 1952

Voucher Number (e.g. 165999917J-16042020) (Required)

165999917J-16042020

► More Information about Voucher Number

Date of expiry for client's current voucher (Required)

Day (dd) *Month (mm)* *Year (yyyy)*

10 - 10 - 2025

Note: If the request for Revalidated Service is within 3 months of the voucher expiry date, please reconsider the request. Determine if the client's circumstances in hearing or health has changed significantly or if the reason to reassess or refit is **urgent** e.g. risk of harm/danger if this service is not provided before their current voucher expires.

2. Provider Details

Please provide details of the provider below.

Provider Trading Name (Required)

Trading Name

Provider Number (Required)

%%%

Provider Email (The outcome will be sent to the address provided here).
(Required)

example@emailaddress.com

► More Information about Provider Email

Qualified Practitioner Name (Required)

QP Name

Qualified Practitioner Number (Required)

1234567X

Telephone Number (Required)

(02) 1234 5678

Part 2 – Reason for Request for a Revalidated Service

Required Information for Reason A

Reason A should be selected if the client's hearing thresholds have permanently deteriorated by **15dB or more** at two or more frequencies between 500Hz and 4000Hz in at least one ear. The following information is required for Reason A and should be included on the request form.

- Results of the previous audiogram
- Results of a recent audiogram/screening test
- Tympanometry results if bone conduction testing was not completed.

► Successful Submission Example - Reason A

Required Information for Reason B

Reason B should be selected if your client is eligible for refitting under the current ECR guidelines but a fitting has already been claimed on their current voucher. The following information is required for Reason B and should be detailed on the request form.

- Claim item number to be claimed
- ECR under which you are refitting
- Clinical justification for the refit
- Evidence to support the refit

► Successful Submission Example for Reason B ECR 1

► Successful Submission Example for Reason B ECR 2

► Successful Submission Example for Reason B ECR 3

► Successful Submission Example for Reason B ECR 4

► Successful Submission Example for Reason B ECR 5

Please select the reason for requesting a Revalidated Service

(Required)

- (●) Reason A – client requires a reassessment (800/810)
- ( ) Reason B – ECR 1
- ( ) Reason B – ECR 2
- ( ) Reason B – ECR 3
- ( ) Reason B – ECR 4
- ( ) Reason B – ECR 5

Please note: Reason B – ECR 1 should only be selected if the client's hearing thresholds have permanently deteriorated by 15dB or more at two or more frequencies between 500Hz and 4000Hz in at least one ear. If the client's device(s) are no longer suitable for a different reason, please review the Eligibility Criteria for Refitting and select a different ECR.

Please select the claim item number to be claimed

Claim item number (Required)

800 (and 810 where required) ▾

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Part 3 – Supporting Evidence for Reason A

Reassessment, item 800 and/or item 810, is required due to a significant deterioration in hearing.

► Successful Submission Example for Reason A

1. Audiogram

Reason A should be selected if the client's hearing thresholds have permanently deteriorated from the time of the previous audiogram and the most recent audiogram by **≥15dB at 2 or more frequencies between 500 to 4000 Hz in at least one ear**.

Date of previous audiogram (Required)

Day (dd)	*Month (mm)*	*Year (yyyy)*
12	07	2020

Date of most recent audiogram/screening test (Required)

Day (dd)	*Month (mm)*	*Year (yyyy)*
26	06	2022

Please indicate with the tick boxes in the tables below the frequencies where a deterioration in air conduction or bone conduction thresholds of ≥15dB have occurred. **At least two tick boxes for one ear need to be ticked**.

	0.5kHz	0.75kHz	1kHz	1.5kHz	2kHz	3kHz	4kHz
Deterioration in Left Ear (kHz)	☐	☑	☑	☐	☐	☑	☐
Deterioration in Right Ear (kHz)	☐	☐	☐	☐	☐	☐	☐

Please provide the client's most recent 3 Frequency Average Hearing Loss (3FAHL).

Left 3FAHL (Required)

48

Right 3FAHL (Required)

48

2. Tympanometry

Please indicate **Tympanometry results** if bone conduction thresholds are not tested to show that the deterioration is not the result of temporary middle ear dysfunction.

Select Tympanometry Result

Type A

« First | Save and come back later... | Continue ›

Part 4 – Acknowledgement and Completion of Application

By ticking the boxes below,

- ☑ I declare a copy of the Request for Revalidated Service form along with supporting relevant evidence, including the outcome email will be retained on the client record. (Required)
- ☑ I declare that the client has met the MHLT exemption criteria if the client's 3FAHLs are less than 23dB. (Required)
- ☑ I certify that the client's circumstances in hearing or health have changed significantly, and the reason for requesting a revalidated service is urgent, e.g. risk of harm/danger if this service is not provided before their current voucher expires. (Required)
- ☑ I declare that the request for a Revalidated Service has been discussed with the client or their Power of Attorney (POA). Consent has been obtained from the client, or if the client is incapable, consent has been obtained from the client's POA or equivalent. (Required)
- ☑ I understand the Request for Revalidated Service Form and supporting evidence are subject to compliance monitoring, including audit. (Required)
- ☑ I declare the information submitted is true and correct and understand that providing false and misleading information is a criminal offence. (Required)

Completion of Application

Thank you for completing your application to request a Revalidated Service under the Australian Government Hearing Services Program.

Please note, once you submit your application you will not be able to edit or make changes to this online application form. Make sure that you have reviewed your application before submission. The Hearing Services Voucher Operations team will inform you if additional information is required once an initial review of your application has been conducted.

Almost done...

You are about to submit your response. By clicking 'Submit Response' you give us permission to analyse and include your response in our results. After you click Submit, you will no longer be able to go back and change any of your answers.

If you provide an email address you will be sent a receipt and a link to a PDF copy of your response.

Email address

example@emailaddress.com

Your response has been submitted

Your response ID is XXXX-XXXX-XXXX-X. Please have this ID available if you need to contact us about your response.

A receipt for your response has been emailed to you from the address **health.gov.au@mail1.citizenspace.com** with the subject "**Consultation response received - Response ID: XXXX-XXXX-XXXX-X**". If it doesn't appear in your inbox within a couple of minutes, please check your "spam" or "junk" folder.

Thank you for your submission.

Please allow 10 days for an outcome to your Request for Revalidated Service application. For enquiries regarding any application please contact the Program by email Hearing@Health.gov.au, include your response ID number.

Kind Regards,

Voucher Operations Section

Hearing Services Program