## Request for Revalidated Service

Any Request for Revalidated Service needs to be submitted online via the [Online Revalidation Form](https://consultations.health.gov.au/rpgd-hearing/request-for-revalidated-service/).

This document is a copy of the Online Revalidation Form as a tool to assist providers.

The Revalidation Form is to be completed online if you wish to request for a revalidated service for a client with the Australian Government Hearing Services Program. Applications submitted using this form via mail or email will **not be accepted**.

### Part 1 – Client Information

**Client Details**

Please provide client details below

First or Given Name (Required)

Surname/Family Name (Required)

Date of Birth (Required)  
 (dd/mm/yyyy)

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

Date of expiry for client's current voucher (Required)  
 (dd/mm/yyyy)

**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.

**Provider Details**

Please provide details of the provider below.

Provider Trading Name (Required)

Contractor Number (Required)

Provider Email (Outcome email will be sent to this address only) (Required)

Qualified Practitioner Name (Required)  
Qualified Practitioner Number (Required)

Telephone Number (Required)

### Part 2 – Reason for Requesting a Revalidated Service

**Please select the reason for request for a revalidated service**

Please select only one item (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](https://www.legislation.gov.au/Details/F2022N00133/Html/Text#_Toc103859115) and select a different ECR.

**Please select the claim item number to be claimed**

Claim item number (Required)

 800 (and 810 where required)  
 820 – monaural refit  
 830 – binaural refit  
 820/760  
 820/770  
 825  
 830

### Part 3 – Supporting Evidence for Reason A

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

**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)  
 (dd/mm/yyyy)

Date of most recent audiogram/screening test (Required)  
 (dd/mm/yyyy)

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)

Right 3FAHL (Required)

**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

Please select only one item

 Type A  
 Type B  
 Type C  
 Type AD  
 Type AS

### Part 3 – Supporting Evidence for Reason B ECR 1

The current hearing aid(s) are unsuitable because they can no longer be optimised by adjustments or any other modifications to meet current gain requirements.

**1. Audiogram**

Reason B – ECR 1 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 500Hz to 4000 Hz in at least one ear**.

Date of previous audiogram (Required)  
 (dd/mm/yyyy)

Date of most recent audiogram/screening test (Required)  
 (dd/mm/yyyy)

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)

Right 3FAHL (Required)

**2. Fitting Range**

The Hearing Threshold Levels (HTL) in the most recent audiogram referenced above should be assessed against the **fitting range** of the client’s current device(s).

[Fully Subsidised Schedule](http://hearingservices.gov.au/hsoViewWEB/file/fully-subsidised-schedule.pdf)

[Partially Subsidised Schedule](http://hearingservices.gov.au/hsoViewWEB/file/partially-subsidised-schedule.pdf)

Please enter the device code for the client’s proposed device(s) below.

**Note**: If the client has a monaural fitting configuration or a non-scheduled device, please enter **N/A** in the relevant fields below.

Left Ear Device Code (Required)

Right Ear Device Code (Required)

* I declare the client’s current device(s) no longer meet the current gain requirements. (Required)

### Part 3 – Supporting Evidence for Reason B ECR 2

The current hearing device(s) is/are unsuitable because the client can no longer use their device(s) due to a significant deterioration in health, dexterity, cognitive ability or speech discrimination since the last fitting. Please note that lifestyle changes such as the client wearing spectacles or becoming a carer are not valid reasons for a revalidated service.

**1. Audiogram**

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

Left 3FAHL (Required)

Right 3FAHL (Required)

**2. Details of the deterioration**

Please provide **details on the deterioration in client health, dexterity cognitive ability or speech discrimination** since the last fitting.

What type of deterioration has occurred? (Please select all that apply) For ECR 2 requests where deterioration in speech discrimination is nominated, please leave this blank and include details in your supporting statements.

 Health  
 Dexterity  
 Cognitive ability

Date of last fitting (Required)  
 (dd/mm/yyyy)

Date the deterioration was reported (Required)  
 (dd/mm/yyyy)

Describe the deterioration in health, dexterity, cognitive ability or speech discrimination (Required)

**Note**: Changes in client’s life circumstances, including the use of spectacles or becoming a carer, are not valid reasons for refitting under ECR 2, which stipulates a deterioration in **client health, dexterity cognitive ability or speech discrimination**.

**Note**: If the reason for ECR application is due to a deterioration in **dexterity**, please include the necessary evidence to demonstrate why a remote control for the client’s current device(s) is not considered appropriate in this instance.

 I declare that the changes to the client's life circumstances does not include the use of spectacles or becoming a carer. (Required)

**3. Details on the current devices or fitting**Why are the current device(s) no longer suitable? (Required)

**Note:** Compliance monitoring has shown that devices are being fitted without taking into account the suitability of the device or exploring other management options. Please ensure the client’s current device is checked for suitability before considering a refitting.

Regarding the client’s **current** device(s) (at the follow-up appointment)

Was the original fitting deemed successful? (Required)

 Yes  
 No

Were the client’s hearing goals met? (Required)

 Yes  
 No

Was the client able to manage the device(s) independently? (Required)

 Yes  
 No

**Note:** If the answers to the above are ‘No’, the program will investigate the original fitting to ensure this has met program requirements.

Did the client voice any concerns about the device(s) and/or fitting? (Required)

 Yes  
 No

If yes, please describe below if their concerns were addressed and resolved

**4. Details on how the current issues were addressed**

Please provide details on the **attempts to resolve issues with the current device(s)**.

Is there a family member or carer (e.g. nursing home staff) able to assist the client with their current device management? (if yes, this application should not be submitted) (Required)

 Yes  
 No

Has a remote control been considered to assist the client with the current device management? (if no, please consider if supplying a remote would be more appropriate) (Required)

 Yes  
 No

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

**5. Details on proposed solution**

Please provide details on the proposed solution.

[Fully Subsidised Schedule](http://hearingservices.gov.au/hsoViewWEB/file/fully-subsidised-schedule.pdf)

[Partially Subsidised Schedule](http://hearingservices.gov.au/hsoViewWEB/file/partially-subsidised-schedule.pdf)

**Note**: If the client has a monaural fitting configuration please enter **N/A** in the relevant fields below.

Left Ear Device Code (Required)

Right Ear Device Code (Required)

Describe what new device(s) are proposed and how will they address the current issue (Required)

**6. Doctor's letter**

* Please note: this letter is not required where deterioration in speech discrimination is nominated.  
  I declare that a doctor’s letter has been obtained that clearly states the date and condition/ deterioration in health, dexterity and/ or cognitive ability the client experiences.

Please provide details of the doctor stated on the letter below.

Name of Medical Practitioner

Name of the medical clinic or hospital

### Part 3 – Supporting Evidence for Reason B 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.

**1. Audiogram**

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

Left 3FAHL (Required)

Right 3FAHL (Required)

**2. Details of the change in physical condition**

Describe the change in physical condition of the ear or ear health. (Required)

If the client has had ear surgery, please provide the date and details of the surgery.

**3. Details on how the issues were addressed**

Please detail the attempts to resolve issues with current devices.

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

### 4. Details on the proposed solution

Please provide details on the proposed solution.

[Fully Subsidised Schedule](http://hearingservices.gov.au/hsoViewWEB/file/fully-subsidised-schedule.pdf)

[Partially Subsidised Schedule](http://hearingservices.gov.au/hsoViewWEB/file/partially-subsidised-schedule.pdf)

**Note**: If the client has a monaural fitting configuration, please enter **N/A** in the relevant fields below.

Left Ear Device Code (Required)

Right Ear Device Code (Required)

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

### 5. Doctor's letter

 I declare that a doctor’s letter has been obtained that clearly states the date and change in physical condition of the ear or ear health the client experiences. (Required)

Please provide details of the doctor stated on the letter below.

Name of Medical Practitioner (Required)

Name of the medical clinic or hospital (Required)

**Part 3 – Supporting Evidence for Reason B ECR 4**

The current device(s) are unsuitable because the client requires a telecoil, and current device(s) do not have a telecoil.

Please note this situation does **NOT** allow for refitting with an FM system/streamer or equivalent.

**1. Audiogram**

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

Left 3FAHL (Required)

Right 3FAHL (Required)

**2. Details of the client’s needs**

Did the client opt out of a telecoil from the previous fitting? (Required)

 Yes  
 No

Describe the change in client’s needs since the last fitting and why they now require a telecoil option. (Required)

 I declare the client is not being refitted with an FM system, streamer or equivalent under ECR 4. (Required)

**Part 3 – Supporting evidence for Reason B ECR 5**

Client currently fitted with an Assistive Listening Device (ALD) and now requires hearing aid(s)

**1. Audiogram**

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

Left 3FAHL (Required)

Right 3FAHL (Required)

**2. Does the client's current ALD meet their hearing needs?**

(Required)

 Yes  
 No

**3. Have the client's circumstances changed since the last fitting?**

(Required)

 Yes  
 No

**4. Details of the client’s change in circumstances**

Describe the change in client circumstances that now requires a hearing aid refitting. (Required)

**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’s file. (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 is 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)