



# Request for a revalidated service

## Client Details

Surname/Family Name

First or Given Name

Voucher 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](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

Date

#POA may only sign on client behalf

#Power of Attorney

## Provider Details

Provider Trading Name

Provider E-mail

Qualified Practitioners Name

Telephone Number

Qualified Practitioner Signature

Date

### 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 fillable 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 requested supporting evidence should be attached when emailing [hearing@health.gov.au](mailto:hearing@health.gov.au).

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

## Reason A – client requires a reassessment

Reason	Supporting Evidence	Evidence on client file
A. Significant deterioration in hearing	<ul style="list-style-type: none"> <li>Enter the results of the <b>previous</b> audiogram (from the last 600/800 assessment) and most <b>recent</b> audiogram/screening test (from the last review item 930/940) in the table below indicating deterioration in air conduction or bone conduction thresholds of <b>≥15dB at 2 or more frequencies between 500 to 4000 Hz in at least one ear.</b></li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li><b>Tympanometry results</b>, if bone conduction thresholds are not tested.</li> </ul>	
<b>Revalidated service item</b> 800 – Reassessment and 810 (audiological case management if applicable)		

### Supporting Evidence for Reason A - item 800 and/or item 810

Please enter the results of the **previous** audiogram (from the last 600/800 assessment) and most **recent** audiogram/screening test (from the last review item 930/940) in the table below 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.**

Test Date		Left Ear Results (KHz)							Right Ear Results (KHz)						
		0.5	0.75	1	1.5	2	3	4	0.5	0.75	1	1.5	2	3	4
Previous Audiogram Date	AC														
	BC														
Current Audiogram Date	AC														
	BC														

#### AND

Please indicate the **Tympanometry results**, if bone conduction thresholds are not tested, to show that the deterioration is not the result of temporary middle ear dysfunction. Please select the appropriate tympanometry result from the drop down list.

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

Revalidated service item <i>(please select one or more items)</i>	Select	
<p>820 – Refitting and rehabilitation (monaural) or 821 – Refit with no follow up appointment (monaural)</p> <p>830 – Refitting and rehabilitation (binaural) or 831 – Refit with no follow up appointment (binaural)</p> <p>825 – Refitting and rehabilitation (ALD) or 826 – Refit ALD with no follow up appointment</p> <p>760 - Subsequent initial fitting, rehabilitation and maintenance or 761 – Subsequent fitting with no follow up appointment</p> <p>770 - Subsequent initial fitting, rehabilitation and maintenance or 771 – Subsequent fitting with no follow up appointment</p>		
Reason	Supporting Evidence	Evidence on client file
<p>B. Client is eligible for refitting under the Refitting Requirements and a device fitting has been claimed against the current voucher.</p>	<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></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>	

## Supporting Evidence for Reason B and ECR 1

**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.

### Hearing thresholds

Please enter the results of the **previous** audiogram (from the last 600/800 assessment) and most **recent** audiogram/screening test (from the last review item 930/940) in the table below 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**.

Test Date		Left Ear Results (KHz)						Right Ear Results (KHz)							
		0.5	0.75	1	1.5	2	3	4	0.5	0.75	1	1.5	2	3	4
Previous Audiogram Date	AC														
	BC														
Current Audiogram Date	AC														
	BC														

### Hearing aid fitting range

Please attach the **fitting range** for the client's current device/s.  
(please take a screen shot attach to application)

## Supporting Evidence for Reason B and ECR 2

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

**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 or cognitive ability since last fitting.

### Details about deterioration in client health

What type of deterioration has occurred? <i>(please select all that apply)</i>	Health	Dexterity	Cognition
Date deterioration reported?			
Describe the deterioration in health, dexterity or cognition.			

### Details about the current fitting

Why are the current device/s no longer suitable?	
<b>Regarding their current device/s (at the follow-up appointment)</b>	<b>Y / N</b>
1. Were the clients hearing goals met?	
2. Was the client able to manage the device independently?	
Did the client voice any concerns about the device and/or fitting? <i>(if yes, please describe below if their concerns were addressed and resolved)</i>	

## Attempts to resolve issues with current devices

Is there a family member or carer (e.g. nursing home staff) able to assist the client with their current device management? <i>(if yes, this application should not be submitted)</i>	<b>Y / N</b>
Has a remote control been considered to assist the client with the current device management? <i>(if no, please consider if supplying a remote would be more appropriate)</i>	
Describe what has been tried with the current device/s and why they cannot be modified.	

## Proposed solution

	Left	Right	Category 1 <sup>1</sup>	Category 2 <sup>2</sup>	Category 3 <sup>3</sup>	Non-Standard <sup>4</sup>
<b>Proposed device/s</b>						
Describe what new devices are proposed and how will they address the current issue.						

## Doctor's letter

Please attach a **doctor's letter** that clearly states the date and condition/deterioration the client suffers from.

<sup>1</sup> Category 1 devices include high powered devices.

<sup>2</sup> Category 2 devices include standard behind-the-ear (BTE) devices.

<sup>3</sup> Category 3 devices include custom devices such as In-the-Canal (ITC), In-the-Ear (ITE) and Completely-in-the-Canal (CIC).

<sup>4</sup> Non-standard (NS) devices include, Assistive Listening Devices (ALDs), Contralateral Routing of Signal (CROS) and Bilateral-CROS (BiCROS) devices, body aids and bone-conductor aids.

## 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.*

### Ear surgery

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

### Attempts to resolve issues with current devices

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

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

## Proposed Solution

	Left	Right	Category 1	Category 2	Category 3	Non-Standard
Proposed device/s						

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

## 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.



## Supporting Evidence for Reason B and ECR 4

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

**ECR 4** - The current hearing aid(s) are unsuitable because the client requires a telecoil, and current hearing aid(s) do not have a telecoil.

	Y / N
Did the client opt out of a telecoil from the previous fitting?	

### Change in client goals

*Describe the change in client needs since the last fitting and why they now require a telecoil option.*

## Supporting Evidence for Reason B and ECR 5

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

**ECR 5** - Client currently fitted with an Assistive Listening Device (ALD) and now requires hearing aid(s).

### ALD to hearing aid fitting

*Describe the change in client circumstances that now requires a hearing aid refitting.*

## Supporting Evidence for Reason B and ECR 6

**ECR 6** - Client's previous initial fit or refit occurred more than five (5) years ago.

A request for revalidated services is not required for ECR 6.

If the client is eligible for the program

- A return voucher should be issued prior to a refitting
- Evidence supporting a refit should be kept on the client file