HEARING HEALTH CARE associates

MEDICAID PRESCRIPTION FORM

190 Main Street
East Haven, CT 06512
Phone 203-466-3823
Fax 203-467-4327

140 Broad Street
Milford, CT 06460
Phone 203-876-2266
Fax 203-882-9640

Please fill out entire form and mail ORIGINAL back to our office. Thank you.

Patient
Name_____**DOB**_____
Address_____
Phone #_____ **T19#**_____

List ICD 10 diagnosis codes for each service needed (hearing aids, batteries,office visit,supplies)_____

Referring
Practitioner:_____**NPI#**_____
Address_____
_____
Phone #_____**Fax #**_____

Additional Comments: Medically necessary repairs, service, supplies, including batteries and ear molds for up to two (2) years.

_____
_____
_____

I have medically evaluated this patient on *MM____ / DD____ / YYYY_____* **and found that they need hearing aid(s) and that there is no contraindication for hearing aid use.**
(Medical evaluation must be within past 6 months for NEW HEARING AIDS)

Prescribing Doctor Signature:_____ **Date**_____

****MUST BE ORIGINAL SIGNATURE****