

**C659**

## HEARING LOSS SERVICES

### Hearing Aid Invoice

#### WORKER DETAILS

|                      |                                       |                              |
|----------------------|---------------------------------------|------------------------------|
|                      |                                       | WCB Claim Number<br>[Claim#] |
| Surname<br>[Surname] | First Name and Initial<br>[FirstName] | Date of Birth (yyyy/mm/dd)   |
| Telephone Number     |                                       | Date of Service (yyyy/mm/dd) |

| Hearing Device  | Code     | * Manuf. Cost | Shipping Cost | Fitting Fee | Total Cost |
|---|----------|---------------|---------------|-------------|------------|
| Monaural <input type="checkbox"/> L <input type="checkbox"/> R                        | *HL03M   | \$            | \$40          | \$498.40    | \$         |
| Monaural <input type="checkbox"/> L <input type="checkbox"/> R<br>Li-ion Rechargeable | *HL03MR  | \$            | \$40          | \$498.40    | \$         |
| Binaural  | *HL03BA  | \$            | \$80          | \$996.80    | \$         |
| Binaural Li-ion Rechargeable  | *HL03BAR | \$            | \$80          | \$996.80    | \$         |
| Cros/Bi-Cros  | *HL03W   | \$            | \$40          | \$666.40    | \$         |
| Cros/Bi-Cros Transmitter  | *HL03T   | \$            | N/A           | N/A         | \$         |
| Amplified Telephone   | *HL07    | \$            | 15% \$        | \$25        | \$         |

\* Per contract Manufacturer's invoice must be attached for goods and services purchased (as applicable)

| Batteries                     | Code   | Quantity | Cost |
|-------------------------------|--------|----------|------|
| Batteries – Right ear         | HL23R  |          | \$   |
| Batteries – Left ear          | HL23L  |          | \$   |
| Batteries size 10 – Right ear | HL23AR |          | \$   |
| Batteries size 10 – Left ear  | HL23AL |          | \$   |

| Incidental Items           | Code | Quantity | Cost |
|----------------------------|------|----------|------|
|                            |      |          | \$   |
|                            |      |          | \$   |
|                            |      |          | \$   |
|                            |      |          | \$   |
| <b>Total Amount Billed</b> |      |          | \$   |

#### Client and Service Provider Sign-off

☐ I completed my \_\_\_\_\_ day trial period to assess my hearing aid(s). My hearing aid(s) are beneficial to me, and I have decided to keep them. I understand that lost, stolen and damaged hearing aids will not be replaced by WCB. If problems arise with my hearing aid(s) I will return to the provider in a timely manner.

☐ I hereby certify that I have received the above goods.

(Signature of WCB Client) \_\_\_\_\_ Date: (yyyy/mm/dd)

I agree that since I have chosen a hearing aid and/or incidental item(s) that is more expensive than that approved by the WCB, I will be solely responsible for the additional cost for this aid and/or incidental item(s) and any additional cost incurred in repairing this aid over that aid approved by the WCB. Any such payment required will be a matter between myself and the provider.

(Signature of WCB Client) \_\_\_\_\_ Cost Share Amount: \$ \_\_\_\_\_ Date: (yyyy/mm/dd)

I hereby certify that I have rendered the above goods and/or services to the client named above in accordance with all of the standards of the WCB Hearing Aid Program.

(Signature of Service Provider) \_\_\_\_\_ Date: (yyyy/mm/dd)

|  |                      |                         |
|--|----------------------|-------------------------|
| Name and mailing address of Service Provider | Invoice # _____ :    | Telephone Number: _____ |
|  | WCB Billing #: _____ | Fax: _____              |

**THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.**  
Invoices must be submitted within six months after Date of Service

## Hearing Aid Invoice

|                        |   |                              |
|------------------------|---|------------------------------|
| (Surname)<br>[Surname] | (First Name and Initial)<br>[FirstName] | WCB Claim Number<br>[Claim#] |
|------------------------|---|------------------------------|

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

**SERVICE LEGEND**

| DESCRIPTION                                  | SERVICE CODE | RATE     |   |
|--|--------------|----------|---|
| Ear mold(s) – manufacturer cost              | HL09         |          | Manufacturer cost   |
| Ear mold(s) – clinic cost                    | HL10         | \$50.00  | Maximum of 2 calls  |
| Repairs – out of office                      | HL11         | \$65.00  | Maximum of 2 calls  |
| Repairs – In office                          | HL12         | \$30.00  | Maximum of 2 calls  |
| Repairs in office – maintenance              | HL12M        | \$30.00  | Maximum of 2 calls  |
| Repairs – manufacturer cost                  | HL13         |          | Manufacturer cost   |
| Hearing aid return fee                       | HL14         | \$48.00  | Once per claim  |
| Cerumen management                           | HL15         | \$20.00  | Maximum of 3 calls per year   |
| Auditory Brainstem Response                  | HL16         | \$175.00 |   |
| Home visit – travel time                     | HL17         | \$65.00  | Per hour – outside city limits  |
| Home visit – clinical time                   | HL18         | \$65.00  | Per hour – outside city limits  |
| Home visit – mileage                         | HL19         | \$0.58   | WCB rate  |
| Wax guards                                   | HL20         |          | \$16.00 max per package of 10   |
| Dry aid kits                                 | HL21         |          | \$22.00 maximum cost per kit  |
| Hearing protection – ear                     | HL22E        |          | Maximum of \$80.00 per pair<br>Once per claim                         |
| Hearing protection – ear – clinic fee        | HL22EC       | \$50.00  | Maximum of 2 calls  |
| Hearing protection – muff                    | HL22M        |          | Once per claim  |
| Battery tester                               | HL24         |          | \$20.00 maximum once per claim  |
| Ear mold tubing                              | HL25         |          | \$10.00 each maximum cost   |
| Hearing loss – other (no shipping charges)   | HL27         |          |   |
| Phone repairs                                | HL28         |          |   |
| Dessicant pucks                              | HL29         |          | \$13.00 maximum per package of 3                                      |
| Eargene                                      | HL30         |          | \$10.00 each maximum cost   |
| Oto-ease                                     | HL31         |          | \$5.00 each maximum cost  |
| Sanitizer spray                              | HL33         |          | \$10.00 each maximum cost   |
| Telephone pads                               | HL34         |          | \$4.00 each maximum cost  |
| Miracell                                     | HL35         |          | \$10.00 each maximum cost   |
| Audio wipes                                  | HL36         |          | \$10.00 max per package of 36   |
| Sweatbands                                   | HL37         |          | \$30.00 each maximum cost   |
| Domes  | HL38         |          | \$20.00 max per package of 10   |
| Receiver (in the ear)                        | HL39         |          | Manufacturer cost + HL12  |
| Case Conference with Audiology Consultant    | HL40         | \$27.50  | Must be initiated by WCB  |
| Report of Medical Opinion with Assessment    | HL41         | \$100.00 |   |
| Report of Medical Opinion without Assessment | HL42         | \$48.00  |   |
| Chart copies                                 | HL43         | \$32.94  | + \$0.40 per additional page  |
| Shipping to worker                           | HL44         |          | Receipt required  |
| New Hearing aid adjustment and verification  | HL04         |          | One time payable within 6 months of Date of Fitting                   |
| New Rechargeable aid accessories             | HL45         |          | Price of accessory + applicable repair code (in office/out of office) |

\* Per contract, Manufacturer's invoice must be attached for goods and services purchased (as applicable)

|                       | Battery Codes |  |                 |
|-----------------------|---------------|--|-----------------|
| Batteries – Right ear | HL23R         |  | 60 max per year |
| Batteries – Left ear  | HL23L         |  | 60 max per year |

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Hearing Aid Invoice

|           |                          |                  |
|-----------|--------------------------|------------------|
| (Surname) | (First Name and Initial) | WCB Claim Number |
| [Surname] | [FirstName]              | [Claim#]         |

|                               |        |  |                  |
|-------------------------------|--------|--|------------------|
| Batteries size 10 – Right ear | HL23AR |  | 100 max per year |
| Batteries size 10 – Left ear  | HL23AL |  | 100 max per year |