Hearing Aid Benefit Request

For Patients Aged 10 And Older

gems
Government Employees Medical Scheme

(Please contact GEMS directly for the process to follow if your patient is younger than 10 years.)

Section A: Patient details

Membership no. ID no.

Surname

Full name

Email

Tel Work Celphone no.

Dependant code ID no. Date of birth D D M M Y Y Y Y

Surname

Full name

Email

Tel Work Celphone no.

Section B: Healthcare provider details

Details of the audiologist or acoustician who will be providing the hearing aid fitting and ongoing care

HPCSA No.

Surname

Full name

Name of practice

Group practice no. Personal practice no.

Physical address

Email

Contact no. Date of test D D M M Y Y Y Y

Section C: Hearing aid information

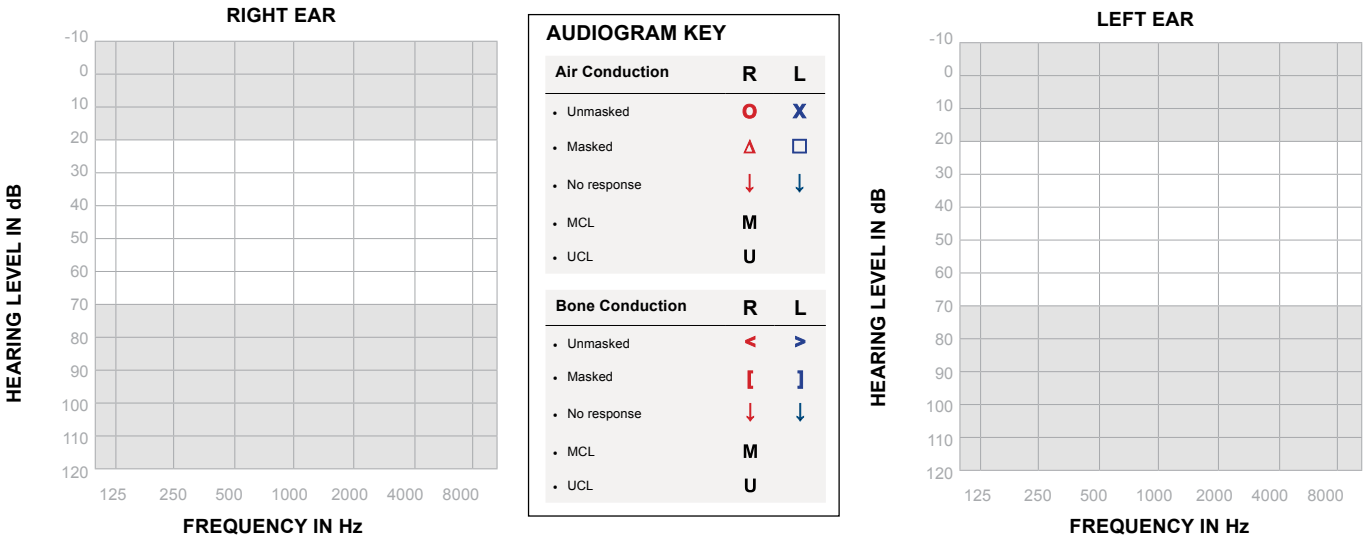
Right ear				Left ear			
Procedure code		ICD-10 code		Procedure code		ICD-10 code	
NAPPI code		Cost (VAT incl)		NAPPI code		Cost (VAT incl)	
Manufacturer		Model		Manufacturer		Model	

Section D: Summary of motivation for hearing aids

Right ear		Left ear	
Type of hearing loss		Type of hearing loss	
Degree of hearing loss		Degree of hearing loss	
Previously worn hearing aid	☐ Yes ☐ No	Previously worn hearing aid	☐ Yes ☐ No

Section E: Clinical results

E1: Pure tone audiogram (include UCL and MCL)



AC @ 1kHz

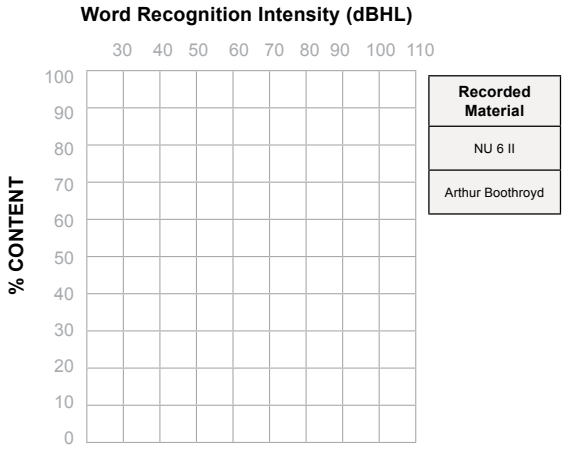
AC @ 1kHz

E2: Immitance

TYMPANOGRAM	R	L
Type		
Pressure		
Volume		
Compliance		

E3: Word recognition (Word and sentence tests in both quiet and in noise)

	RIGHT	LEFT	Sound-field
PTA (Pure Tone Average)	dB	dB	dBS
Speech Reception Threshold	dB	dB	dBs
Max Word Recognition	%	%	%
SDT (Speech Detection Threshold)	dB	dB	dBS



Recorded speech perception tests				
Test Materials	dB	Right/Left/Sound-Field/Binaural	SNR	% Correct

E4: Summary of results and/or additional motivation for hearing aid benefit

Section F: Examiner declaration

I hereby certify that I personally identified and examined the applicant named on this pre-authorisation form and that this information, together with attached notes, embodies my hearing evaluation completely and correctly. I consent to provide Medscheme with additional information or evidence upon request. This may include further diagnostic assessment results as well as proof of equipment calibration certification.

Signature of practitioner _____ Signature of patient _____ Date D D M M Y Y Y Y