MEDICAL CLEARANCE EXAMINATION FORM
FOR HEARING AID COVERAGE

Dear Member:

Your MESSA health plan includes a hearing aid program. To qualify for benefits, the patient must receive a Medical Clearance Exam from a physician. The physician will then refer the patient to a physician-specialist for further hearing services.

❶ The physician must complete the reverse side of this form to certify that the exam is complete and that the patient is a candidate for a hearing aid.

❷ The patient must take the completed form to the appointment with the physician-specialist who will be performing additional hearing services.

❸ The physician-specialist will attach the Medical Clearance Examination form to the claim form and submit both forms to MESSA.

If you have any questions, please contact MESSA Benefits at 800/336-0013.

MESSA

www.messa.org

Michigan Education Special Services Association

1475 Kendale Blvd., P.O. Box 2560

East Lansing, Michigan 48826-2560

517.332.2581 • 800.292.4910

MES - CK012
Pr. 9/01 - 3M

Dear Physician:

The MESSA hearing aid program requires that the member and/or covered dependent receive a medical clearance exam to certify the patient is a candidate for a hearing aid. The physician can then refer the patient to a physician-specialist for further hearing services.

Your completion of this form will certify that the exam is complete and the patient is a candidate for a hearing aid, and will introduce the patient to the physician-specialist. The physician-specialist must submit this signed clearance form with the claim as authorization for services.

NOTE: *The medical clearance or hearing loss examination is covered under the member's standard medical care benefits.*

This form must be completed by your Physician.

MESSA Hearing Aid Program

MEDICAL CLEARANCE

Member's name _____

Address _____

City _____ State _____ Zip _____

Member's Social Security number _____

Patient's name & relationship to member _____

Patient's birth date _____

I have provided a medical examination of the ☐ right, ☐ left, ☐ both ear(s) for *(name of patient)* _____ on *(date of service)* _____

and certify that he/she may be considered a candidate for a hearing aid. I am therefore referring this patient for further audiological evaluation and testing.

Signature of physician _____

The physician-specialist must attach this form to the member claim for service and submit to MESSA.