State of Illinois
Department of Healthcare and Family Services

APPENDIX E-3b
BINAURAL HEARING AID QUESTIONNAIRE

Patient Name _____ RIN _____ Birth Date _____

In order to make an informed decision for coverage of a binaural hearing aid system, the following information is required:

1. Was the participant's hearing tested in an acoustically treated sound suite? Yes ☐ No ☐

   If the response is no, where were the hearing tests performed?

2. What date were the hearing tests performed? _____

   By whom (please provide practitioner's name and type)?

3. Document the hearing test results below: (provide decibels and frequencies for both ears)

   Right Ear _____ Left Ear _____

   Please attach a copy of the comprehensive hearing tests performed.

   Are there results from previous hearing tests that the practitioner reviewed for comparisons? Yes ☐ No ☐

   If the response is yes, what is the date of the previous testing and the results?

   Were the tests performed by the current practitioner? _____

4. Please describe what other types of hearing devices have been used in the past, and whether these devices were effective?

5. Why is it necessary this participant have a binaural system?

6. Please describe any additional factors unique to this patient that should be considered during the prior approval review:

Audiologist/Physician/Practitioner signature and degree **Date**