This section must be completed by the hearing professional who performed the hearing test.
You must include a copy of that current hearing test (audiogram).
The Lighthouse does not pay for hearing tests.

Medical Condition & Clearance

Child's Primary Diagnosis: ____

I recommend the following treatment(s): ____

Are there any medical barriers to treatment? Yes No

If yes, please list: ____

I certify that _________________________ (**applicant name**) was medically examined on ___/____/___ and may be considered a candidate for hearing aid use. ***Must be signed and dated by a licensed physician (M.D.)***

____ ____/____/____
Signature of M.D. Date

____ ____
Name of M.D. (Please Print) Name of Physician's Practice

Provider Recommendation for: ___________________________
Print Patient's Name

Business Name: ____

Name and Title of Hearing Professional: ____

Phone Number: _______________________________ Fax Number: __________________________________

Address: ____

City: ______________________________________ State: __________________ Zip Code: ________________

Email Address: ____

Please specify degree of hearing loss: Mild Moderate Moderately Severe Severe Profound

Circle the type of hearing aids recommended:

Right Ear: None RIC/BTE ITE BI CROS

Left Ear: None RIC/BTE ITE BI CROS

Is this facility a Lighthouse Provider? Yes No

If no, patient needs to follow instructions on Page 10.

If no, are you interested in becoming a Lighthouse Provider? Yes No

Contact us at 404.325.3630 or visit www.LighthouseGeorgia.org for more information.

Insurance Affidavit

This insurance affidavit must be completed by the hearing professional who performed the hearing test.

I, ____ (full printed name), declare under penalty of perjury that the following is true and correct to the best of my knowledge, information and belief.

Name of Practice: ____

Address: ____

Signature of Provider: ____

I confirm that the following has been verified on the patient listed below:

Name of Patient: ____

__________The patient does not carry medical insurance

__________The patient does carry medical insurance*

*Insurance: (Circle all that apply): Medicaid Peachcare Private Insurance

__________The patient carries medical insurance, but Hearing services are not covered in the policy

A copy of this affidavit is being filed with The Lighthouse in the designated Hearing Program electronic patient filing system. Patient information will be kept on record for a minimum of three years. The Lighthouse accepts the affidavit in good faith.

Provider Print Name: ____

Provider Signature: ____

Date: ____