Clear Form

WCB Nova Scotia
200-137 Venture Run
Dartmouth, NS B3B 0L9

Toll-free: 1-800-870-3331
Fax: 902-491-8001

Hearing Loss Exception to Benefits Form

Please fax or mail the completed form to us using the information on the form.

WCB Claim #:

Complete this form when seeking approval of devices or services that are different from those outlined in the WCB *Hearing Health Services Guide*.

WORKER INFORMATION

Worker's Last Name:	First Name:	Initial:	Date of Birth (dd/mm/yyyy):

SERVICE PROVIDER INFORMATION

Audiologist/Hearing Instrument Specialist:	Clinic:	
Address:	City:	Province: NS
Phone:	Fax:	ID#

PURPOSE OF THE REQUEST

Please indicate the service(s) being recommended:

- ☐ Increased frequency of re-fitting
- ☐ Additional Batteries
- ☐ Accessories
- ☐ Additional Maintenance
- ☐ Advanced Dry Aid Kit (submit proof of at least 2 repairs in past 12 months due to moisture)
- ☐ Tinnitus Assessment
- ☐ Other:

HEARING AID(S)

Please indicate the hearing aid(s) recommended along with a rationale to support the request.

- ☐ Hearing Aid (submit proof of trial period with an approved aid)
- ☐ Hearing Aid from List B ($950 cap)
- ☐ Hearing Aid not from Approved List

Vendor:

Product:

Model #:

Price:

PLEASE PROVIDE REASONING/RATIONALE TO SUPPORT THE REQUEST(S) ABOVE (ADD ADDITIONAL PAPER AS REQUIRED)

HEARING AIDS – COST SHARING: TO BE COMPLETED BY THE WORKER

Complete this section if the recommended device requires a cost-sharing arrangement between the worker and clinic.

In a cost-sharing arrangement, WCB will reimburse the provider a maximum of $750.00 towards the purchase of a device for workers who are eligible for coverage. The worker is responsible for paying the difference between the manufacturer's cost and the amount invoiced to WCB.

☐ By signing, I acknowledge and understand my provider is seeking approval on my behalf to purchase a device separate from WCB's approved device list. I understand that, if approved, WCB will pay a maximum of $750.00 towards the cost of a hearing device and I will be responsible for the cost difference, payable directly to the clinic.

Worker Signature: Date:

Signature of provider: _____ Date: _____