

**AUDIOLOGY PROVIDER / AUDIOLOGIST / CLINIC DETAILS**

Audiologist Given Name \_\_\_\_\_ Accreditation No. \_\_\_\_\_  
 Audiologist Last Name \_\_\_\_\_ Email \_\_\_\_\_  
 Telephone \_\_\_\_\_ Ext No. \_\_\_\_\_ Mobile \_\_\_\_\_  
 Audiology Provider (trading as) & Branch \_\_\_\_\_

**Fill out the following if the application information is to be sent to an alternative Audiology Provider:**  
 Alternative Audiology Provider & Branch \_\_\_\_\_  
 Alternative Email \_\_\_\_\_  
 Date      /      /     

**Approved Assessor / Audiologist Declaration**  
 By completing and submitting this request I confirm that the completion of the repair or provision of the replacement part to completion will be carried out in accordance with the NZAS Standards of Practice and the Ministry of Health's Disability Support Services accreditation framework and that the request is correct and meets the Ministry of Health's Hearing Aid Funding Scheme eligibility criteria and processes.  Yes  
 No

**PERSON'S DETAILS**

Given Name \_\_\_\_\_ Title \_\_\_\_\_  
 Last Name \_\_\_\_\_ NHI No. \_\_\_\_\_  
 Address Line One \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address Line Two \_\_\_\_\_ Date of Birth      /      /       
 Suburb \_\_\_\_\_ Gender \_\_\_\_\_  
 City / Town \_\_\_\_\_ Ethnicity \_\_\_\_\_  
 Postcode \_\_\_\_\_ Person's Email \_\_\_\_\_

**ELIGIBILITY – select one**

- Preschooler, child or young person in full time education up to 21 years of age
- Adult with complex needs – severe since childhood / sudden & severe / dual disability
- Adult with Community Services Card and working / studying / volunteering / carer of a dependent person

**REPLACEMENT PART – CHILDREN & YOUNG PEOPLE ONLY**

**Child – replacement domes & tubes / custom earmoulds & shells for existing hearing aids.**  
 Audiologist sends order to Manufacturer using a code made up of the pre-fix HAR with the child's NHI #, and include the child's name & date of birth. Manufacturer completes the order and invoices accessible including the above details plus the Audiologist / Audiology Provider's name. accessible matches the invoice to the Audiologist's Repair / Replacement Part request for payment.

**Describe the replacement part, quantity, date of order and manufacturer's name:**

**Total Number of pages in this Request** \_\_\_\_\_ Please count all pages including any cover sheets and attachments. Record the number here.

**REPAIR OR REPLACEMENT PARTS – ADULT ONLY**

- Assessor:** Manufacturer repair or replacement part is completed as the cost is lower than \$235 exclusive GST per hearing aid or accessory per 2 year period.  
Audiology Provider attaches their invoice including a copy of the Manufacturer's itemised quote / invoice for the repair / replacement part and sends this to **accessible** for payment.
- Services Manager:** Repair or replacement part cost exceeds \$235 exclusive GST Assessor Pre-Approval threshold.  
Audiology Provider attaches a copy of the Manufacturer's quote for the repair or replacement part and sends this to **accessible** for funding consideration.

**REPLACEMENT OPERATIONAL PART DETAILS**

- Replacement domes & tubes / custom earmoulds & shells for existing hearing aids.

**REPAIR DETAILS**

- Hearing Aid**  
 Manufacturer, Model & Style \_\_\_\_\_ Serial Number Left Ear \_\_\_\_\_  
 Manufacturer, Model & Style \_\_\_\_\_ Serial Number Right Ear \_\_\_\_\_

- Accessories (e.g. remotes, connectivity devices)**  
 Manufacturer, Model & Style \_\_\_\_\_ Serial Number \_\_\_\_\_

- FM System**  
 Manufacturer, Model & Style \_\_\_\_\_ Serial Number \_\_\_\_\_

- Other (please advise)**  
 Describe the repair required:

**TO BE COMPLETED BY HEARING AID SERVICES MANAGER**

- Approved**                       **Declined**                      Query: \_\_\_\_\_

Date dd / mm / yyyy \_\_\_\_\_

Purchase Order Number: \_\_\_\_\_

**Notes:**