B. 43 Physician's Examination Report

Client Name (Last, First, M)	Client No.	Date of Birth
Address (Street, City, State, Zip Code)		

1. Date of Examination*

2. Ear Examination:

a. Within Normal Limits ❒Yes ❒No

b. Cerumen Removed ❒Yes ❒No

c. Describe Ear Abnormalities:

3. Is more otolaryngological examination/treatment required to provide medical clearance for the fitting of a hearing aid? ❒Yes ❒No
If yes, refer this patient for consultation and completion of this form.

4 . Are there any medical contradictions to hearing aid usage in either ear? ❒Yes ❒No
If yes, a hearing aid is medically prohibited in ❒Right Ear ❒Left Ear

5. Is the above-named individual a candidate for a hearing aid evaluation? ❒ Yes ❒No

Signature*· Physician	Physician's Name (please type or print)	Medical Specialty
Address		Telephone No.

***NOTE: PLEASE FURNISH THE PATIENT WITH THE SIGNED AND DATE ORIGINAL AND ONE COPY OF THIS FORM.**
To be reimbursed for the examination, you must submit this completed form along with a claim for the physician's services to the following address:

Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, TX 78727