**Saint John Office**
Toll free: 1 800 999-9775
Local: 506 632-2200
Fax: 1 888 629-4722

# Form HA-01

Hearing Aid Fitting and Service Report
Doc Code (MP) Internal Use Only

| **Worker Name and Address** | **Service Provider Name and Address** |
|---|---|
| **Claim Number** | **Service Provider Payee Number** |

**Date of Worker Appointment/Visit (YYYY-MM-DD)**

**FITTING**

- ☐ Fitting – Based on the Standing Offer Device List
- ☐ Fitting – Based on the Exception Device List ( Please complete and attach HA-02 – Exception report)
- ☐ Fitting – Worker Funded Upgrade – Exception Device List

**SUPPLIES**

- ☐ Earmold Blower
- ☐ Dri-Aid Kits
- ☐ Batteries_____Quantity Supplied
- ☐ Ear Hooks
- ☐ Tubing
- ☐ Wax Guard
- ☐ In-House Repair :_____
- ☐ RIC Receiver Replacement

**MAINTENANCE/SERVICES**

- ☐ Adjustment/Reprogramming
- ☐ Cleaning
- ☐ Removal of wax
- ☐ Ear Impression
- ☐ Real Ear Measurements
- ☐ Counselling
- ☐ Re-Instructions

**Comment:**

**MANUFACTURER REPAIR FOR HEARING AIDS LESS THAN 4 YEARS OLD (> 4 years old send HA-02)**

- ☐ Dead
- ☐ Distorted
- ☐ Cracked
- ☐ Internal Feedback
- ☐ Noisy
- ☐ Other (please specify)_____
- ☐ Covered by Warranty
- ☐ Manufacturer Repair Cost $_____
- ☐ Repair Charge $ _____
- ☐ Out of Specifications
- ☐ Remake for Fitting Issues

**Comment:**

**The undersigned declares the above requested services(s) is not the result of abuse or negligence of the worker**

| **YYYY-MM-DD** | **Print Name** | **Signature** |
|---|---|---|
| | | |

**OTHER REASONS FOR VISIT**

Request for:

- ☐ Replacement Aids (send HA-02)
- ☐ Batteries (send invoice)
- ☐ Hearing Assessment (send report)
- ☐ Hearing Re-evaluation (send report)
- ☐ Hearing Aid counseling

| Please attach any related documentation such as Manufacturer Invoices, Hearing Re-Evaluation, or Full Diagnostic Hearing Assessment report<br><br>Total # of Attachments_____Total of Pages Attached_____ | Additional Notes or Comments:<br><br>If you require a response please use the HA-02 Form. |
|---|---|

| Signature of Service Provider | Form Submission Date YYYY-MM-DD |
|---|---|
| | |

Note: If worker claiming mileage for this visit, WorkSafeNB will also use this form as confirmation of visit for mileage reimbursement.