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

Form HA-02

Exception 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)

Is Worker still working? ☐ **Yes** ☐ **No**

REPLACEMENT OF HEARING AID(S)

Reason for replacement: **Fitting date of current hearing aid:**

☐ Significant change in hearing (send current audiogram)

☐ Malfunction or inadequate amplification of the current hearing aid

☐ Combination of change in hearing and malfunction/inadequate amplification of the current hearing aid (send ANSI, current ear measurements to demonstrate if targets can be met and printout of hearing aid settings)

☐ Repair is no longer cost effective as the current hearing aid(s) are older than 4 years old (manufacturer's estimated cost of repair $__________)

☐ Other

Comments:

Recommended device(s):

HEARING AID(S) – EXCEPTION DEVICE LIST

Explain need:

Recommended device(s):

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**

Please attach any related documentation such as Manufacturer Invoices, Hearing Re-Evaluation, or Full Diagnostic Hearing Assessment report Total # of Attachments_________Total of Pages Attached________	Additional Notes or Comments:
Signature of Service Provider	**Form Submitted 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.