WORKSAFE TRAVAIL SÉCURITAIRE NB

Form HA-01
Hearing Aid Fitting and Service Report
Doc Code (MP) Internal Use Only

Please MAIL this form to:
P.O. Box 160
Saint John, N.B.
E2L 3X9

Please fax this form TOLL-FREE to: **1 888 629-4722**

Toll-free telephone number: **1 800 222-9775**

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

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

Hearing Aid Original Purchase Date YYYY-MM-DD	**Hearing Aid Model Name and Serial #**

Please use the check boxes and spaces provided below to indicate the reason for the visit. Complete ALL that apply.

FITTING

☐ **Fitting – Based on Standing Offer Device List**

☐ **Fitting – Based on Exception Device List** (Please complete and attach HA-02 Exception report)

MAINTENANCE/MINOR REPAIR

☐ Cleaning	☐ Reprograming	☐ Removal of wax	☐ Real ear measurements
☐ Adjustments	☐ Wax Guards	☐ Earmold blower	☐ Repair/replace battery doors
☐ Ear hooks	☐ Dri-Aid kits	☐ Ear impression(s)	
☐ Tubing			☐ Other (please specify) _____

Comment: _____

MANUFACTURER REPAIR

☐ Dead ☐ Distorted ☐ Cracked ☐ Internal Feedback ☐ Noisy

Other (*Please specify)* _____ **Manufacturer Repair Cost $**_____

Comment: _____

REPLACEMENT HEARING AID(S)

Please use this space to explain why new hearing aid(s) are required.

BATTERIES

FULL DIAGNOSTIC HEARING ASSESSMENT HEARING RE-EVALUATION

List Attachments *(Please attach any related documentation such as manufacturers' invoices, hearing re-evaluation, or full diagnostic hearing assessment reports.)*	**Additional Notes or Comments:**
Total # of Attachments _____ **Total # of Pages Attached** _____	

Name of treating hearing aid provider	**Form submission date YYYY-MM-DD**

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