Hearing assistive techologies (HAT) request form
for use by
audiologists and hearing instrument specialists

Complete this form when requesting **pre-approval** from the WSIB for the initial purchase of items that can present auditory, visual, or tactile information to people with work-related hearing loss (e.g., telephone amplifiers, television specific devices, alerting systems, *FM systems (*submit audiologist authorization and current hearing assessment) and for the subsequent repair or replacement of HAT.

The HAT categories of products and negotiated manufacturer pricing are available on the TELUS Health provider portal.

For requests to replace non-functioning HAT(s), please include a manufacturer report and/or supporting documentation when submitting this form.

For lost, stolen or damaged HAT(s), please make sure the patient has completed and submitted the *Declaration of lost, stolen or damaged hearing devices form* (10570A) for WSIB consideration of replacement.

For more information related to hearing device benefits or when entitlement has been established for any work-related hearing loss, please refer to the Operational Policy Manual (OPM) document #17-07-04, Hearing Devices.

You can submit the completed form at wsib.ca/submit. If you don't have access to our website, you can also mail your completed form to us.

Hearing assistive technologies (HAT) request form

This form is to be completed by audiologists and hearing instrument specialists. Please read the instructions page before completion.

Claim number

Hearing health care practitioner information		
Clinic name	Clinic phone number	WSIB provider number
Clinic address		Phone number
Hearing health care practitioner's name		Registration number

Patient information		
Last name	First name	Date of birth (dd-mmm-yyyy)
Home address		Phone number

Please indicate the type of request.

Section A: Initial HAT request

Please indicate the following information for the Initial requested HAT.

Initial HAT	Product description	Manufacturer	Model	Product code	Price

Please provide clinical rationale for initial request for HAT.

Section B: HAT request for replacement and lost, stolen or damaged

Please indicate the type of HAT request:

☐ Replacement ☐ Lost ☐ Stolen ☐ Damaged

1.	☐ Yes	☐ No	Has the WSIB previously replaced a HAT for the patient? If yes, please provide supporting documentation and product information on the current HAT model.
2.	☐ Yes	☐ No	Is the HAT within the manufacturer's warranty period?
3.	☐ Yes	☐ No	Has the manufacturer tested the HAT? If yes, please provide supporting documentation.
4.	☐ Yes	☐ No	Is the HAT unrepairable? If yes, please provide supporting documentation.

☐ I have included the manufacturer invoice/repair quote and/or supporting documentation (i.e., manufacturer invoices/repair quote report).

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

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Claim number

Please indicate the following information for the current and requested replacement HAT.

	Model	Serial number	Original dispense date
Current HAT:			

	Product description	Manufacturer	Model	Product code	Price
Requested replacement HAT:					

For replacement only: please provide clinical rationale and details for the reason a replacement HAT is being requested.

For lost, stolen or damaged only: please provide a full explanation of how the patient's HAT was lost, stolen or damaged.

Health care practitioner declaration and signature

By signing below: I understand that it is an offence to deliberately make a false statement to the Workplace Safety Insurance Board; and I declare that all of the information provided above is true.

Audiologist name	Audiologist signature	Date (dd-mmm-yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

Hearing instrument specialist name	Hearing instrument specialist signature	Date (dd-mmm-yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

Patient acknowledgement and signature

By signing below, I acknowledge and understand that my hearing health care provider is seeking approval from the WSIB on my behalf to request a hearing device(s) for the reasons stated above.

Name	Signature	Date (dd-mmm-yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.