Hearing Aid Early Replacement

For use by
Audiologists and Hearing Instrument Practitioners
for hearing aids being replaced prior to 5 years.

If the worker/retired worker has had his/her current hearing aid(s) for less than 5 years and you have determined that new hearing aid(s) are required, this form must be completed and sent to WSIB for pre-approval of the new hearing aid(s).

If the WSIB approves an early replacement hearing aid, a hearing aid model from the primary category is considered for the replacement. For those workers with specific clinical requirements that cannot be met by the hearing aid model from the primary category, a Hearing Aid Special Needs Request form (2869A) must be completed and submitted with relevant supporting documentation for consideration.

For a list of models available in the primary and alternate categories, see the "Hearing Devices" page on the WSIB's website at **www.wsib.on.ca**. For more information regarding the criteria for allowance and payment for the provision, replacement, or repair of hearing devices in cases where work-related hearing loss entitlement has been established, see OPM document #17-07-04, Hearing Devices.

Should you have any questions or concerns about the replacement of the worker/retired worker's hearing aid(s), please do not hesitate to contact us at 416-344-1000 or at our toll free number 1-800-387-0750.

When completing this report, please **print** using **black pen** and be sure to include the claim number.

Please print **pages 2 and 3** and send to the Workplace Safety and Insurance Board:

By fax to:

416-344-4684 or 1-888-313-7373

Or by mail to:

Workplace Safety and Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

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Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

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Hearing Aid Early Replacement

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Claim Number

Please complete in full printing in black ink.

A. Worker Information

Last Name	First Name		
Address (no., street, apt.)			
City/Town	Prov.	Postal Code	Telephone No.

B. Provider Information

Provider Name			Provider No.
Mailing Address (no., street, suite/unit)			Telephone No.
City/Town	Prov.	Postal Code	Fax No.

C. Description of Current Hearing Aid(s)

Current Hearing Aid(s) ☐ in-the-ear ☐ behind-the-ear

	Manufacturer	Model	Serial Number	Manufacturer's Invoice Date	Manufacturer's Cost	Name of Dispensing Clinic
Right Ear						
Left Ear						

D. Description of Proposed Hearing Aid(s)

	Manufacturer	Model	Product Code	Design	Manufacturer's Cost
Right Ear					
Left Ear					

(Please see reverse side)

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Hearing Aid Early Replacement

OD

Claim Number

E. Reason for Requesting Early Replacement - prior to 5 years

Please explain in detail the reason for requesting a replacement hearing aid(s).

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It is an offence to deliberately make a false or misleading statement or representation to the Workplace Safety and Insurance Board. I declare that all of the information provided above is true.

Name of Audiologist or Hearing Instrument Practitioner (please print)	CASLPO or AHIP member #
Signature *Type your name and upload, or print and sign before returning to WSIB.*	Date (dd/mmm/yyyy)

If the proposed hearing aid is not selected from the WSIB's primary category, a Hearing Aid Special Needs Request form and supporting documents must be attached to this form in order for the Early Replacement to be considered.

To avoid delays in processing this request, please ensure that:

- **the claim number is provided**
- **all sections are completed.**

Worker's Signature *Type your name and upload, or print and sign before returning to WSIB.*	Date (dd/mmm/yyyy)

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