Children and Youth with Special Health Care Needs (CYSHCN)

Hearing Aid Battery Request

Client: _____

DOB: _____ **MCI#:** _____

Medicaid#: _____ **Medicaid Plan:** _____

Indicate with a (✓) if client has Left, Right or Both Hearing Aids: **Lt** ☐ **Rt** ☐ **Both** ☐

Left Hearing Aid: _____

(Manufacturer and Model Number)

Right Hearing Aid: _____

(Manufacturer and Model Number)

Battery Size: _____ *(Do Not Indicate How Many Hearing Aids)*

Home Address: _____

_____

City: _____, South Carolina

Zip Code: _____ - _____

Submitted by: _____ **Date:** _____

Hearing Aid Battery Requests are sent to one of the following:

Email:	Fax:	Mail:
cyshcn-hearing@dhec.sc.gov	(803) 898-0613	Admin Asst - Hearing SC DHEC-CYSHCN Mills/Jarrett Complex 2100 Bull Street Columbia, SC 29201

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Instructions for completing the DHEC 4332

Purpose: This is the standard tool used to request hearing aid batteries provided to CYSHCN clients.

Users: This tool will be utilized by CYSHCN staff, external providers, parents and/or clients.

Item-by-Item Instructions:

Individual completing the request will:

1. Enter the name of the individual being referred for hearing aid batteries;
2. Enter the date of birth of the individual being referred;
3. Enter the individual's DHEC medical record number;
4. Enter the individual's Medicaid number;
5. Enter the individual's Medicaid plan;
6. Mark with an ✓ to indicate if the individual has left, right, or both hearing aids;
7. Enter manufacturer and model number for left and/or right hearing aid(s);
8. Enter battery size;
9. Enter the individual's home address;
10. Enter the name of who is submitting this form;
11. Enter the date of the submission;
12. Submit the form to DHEC CYSHCN Central Office via email, fax, or mail at the contact information provided.

Office Mechanics and Filing: This form will be retained by DHEC CYSHCN Central Office. This form is Not filed in the DHEC medical record.