

## Hearing Aid Services Provider Update

**September 15, 2009**

2009 – 57

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The purpose of this bulletin is to provide you with an update on WorkSafeBC's computer system implementation and some reminders.

**1. My battery invoices have not yet been paid, what should I do?**

Please do not re-bill for any items where you have not received a remittance statement indicating that the item has not been paid.

If you have not received a remittance statement regarding the item, it is because the invoiced item is being reviewed. Unfortunately, this process has taken longer than anticipated, but they are being processed.

A suggestion to help facilitate future battery payments is to use the 51W12 invoice instead of the 51D3. The 51W12 invoice contains more worker information, which ensures that the invoice can be matched to a claim. Alternatively, please review all work names and claim numbers on the 51D3 to ensure they are accurate and legible.

**2. I don't understand why I don't receive full payment for an invoice:**

This happens because items are paid by individual line item or fee code, not by invoice total. Some line items may be pending with WorkSafeBC for a decision prior to making payment, while others are paid.

**3. I received a \$0.00 payment. Now what do I do?**

If you received a payment of \$0.00 in error, which has not yet been resolved, WorkSafeBC will be facilitating the correct payment shortly.

**4. My photocopy invoice was not paid. How can I resolve this?**

If your invoice for photocopy fees has not been accepted, please call the Hearing Loss Unit at 604-276-3340.

**5. I am using older WorkSafeBC forms. Is this a problem?**

Please ensure that you are using updated forms to ensure expeditious payment. Forms are available on [www.worksafebc.com](http://www.worksafebc.com) under "forms" / "health care providers" / "hearing aid and related". We have attached examples of the relevant forms.

## 6. Reminders

Please ensure:

- You use the correct date format (yy/mm/dd) on all invoices and forms;
- If you are putting batteries on the 51W12, do not list them under accessories. They need to go into a blank row at the bottom of the invoice using fee item code 19694;
- Do not list any items for \$0.00. Some providers do this for internal accounting processes, but these will be data entered by WorkSafeBC and may cause subsequent payment issues;
- You fax in the copy of the manufacturers' invoice and clearly write "Copy – Not for processing";
- You send in the Hearing Aid Program Cover Sheet (83D110) when required. Each item will need a separate cover sheet.
- You do not put invoices under or with the Cover Sheet. Invoices do not need a fax cover sheet.
- You are entering the number of units, cost per item and line item cost correctly.

Example:

Correct: Fitting Fee 19680: **Number of units: 1**  
Cost per item: \$476.00  
Line item cost: \$476.00

Incorrect: Fitting Fee 19680: **Number of units: 1**  
Cost per item: \$952.00  
Line item cost: 952.00

In closing, we thank you for your understanding as we implement this new system. As always, Health Care Services remains committed to helping you resolve any difficulties you may encounter in doing business with WorkSafeBC.





## HEARING AID REPLACEMENT INFORMATION

**CLAIMS CALL CENTRE**  
Phone 604 231-8888  
Toll-free 1 888 967-5377  
M-F, 8:00 a.m. to 4:30 p.m.

**FAX**  
604 233-9777  
Toll-free 1 888 922-8807

**MAIL**  
WorkSafeBC  
PO Box 4700 Stn Terminal  
Vancouver BC V6B 1J1

Please submit Audiogram AND Real-ear probe microphone/Sound field measurements with WorkSafeBC form 83D110 – Hearing Aid Program Cover Sheet.

### Client information

|  |            |   |                         |
|--|------------|---|-------------------------|
| Worker last name   | First name | Middle initial                              | WorkSafeBC claim number |
| Street address   |            | City  | Postal code             |
| Retired Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, when? (yyyy-mm-dd) |            | Telephone number (please include area code) |                         |

### Clinic information

|                           |              |                   |
|---------------------------|--------------|-------------------|
| Clinic                    | Payee number | Date (yyyy-mm-dd) |
| Mailing address           |              |                   |
| City                      | Postal code  | Telephone number  |
| Licensed service provider |              | Fax number        |

### Description of current hearing aid(s)

|  |  |       |               |             |        |
|--|--|-------|---------------|-------------|--------|
| Present hearing aid is less than 5 years old<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | If "no", and hearing aids are replaced, form 51W12, Hearing Aid Provision and Services Invoice, must accompany for payment. If "yes", authorization is required from WorkSafeBC (the Workers' Compensation Board) Hearing Loss Claims Department before new hearing aid(s) may be dispensed. |       |               |             |        |
|  | Manufacturer   | Model | Serial number | Date fitted | Clinic |
| Right ear  |  |       |               |             |        |
| Left ear   |  |       |               |             |        |
| Repair history   |  |       |               |             |        |

### Reasons to replace hearing aid(s)

|   |                          |                          |
|---|--------------------------|--------------------------|
| <b>Please check appropriate boxes</b>   | <b>L</b>                 | <b>R</b>                 |
| Inadequate gain available   | <input type="checkbox"/> | <input type="checkbox"/> |
| Improper amplification for hearing loss   | <input type="checkbox"/> | <input type="checkbox"/> |
| Improper fit resulting in feedback  | <input type="checkbox"/> | <input type="checkbox"/> |
| Significant change in hearing (>20dB) at 3 or more frequencies (500-4000Hz)           | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing aid style inappropriate (e.g. dexterity, acoustical needs)                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Repair is no longer cost effective (manufacturer's estimated cost of repair \$ _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| Other <input type="checkbox"/>  |                          |                          |
| Explanation   |                          |                          |
| Proposed solution   |                          |                          |

### WorkSafeBC office use only

|  |           |
|--|-----------|
| Recommendation   |           |
| Approved<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | Signature |

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the Workers' Compensation Act and the Freedom of Information and Protection of Privacy Act. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or telephone 604 279-8171.



**RESET**

**HEARING AID PROVISION  
AND SERVICES INVOICE**

This invoice must be submitted within 90 days of the date of service. Please **FAX** or mail completed form to WorkSafeBC as indicated below. **All fields with \* are required for payment to be processed.** Failure to provide this information may result in processing delays. Please complete all other fields (if possible). Incomplete invoices may be returned for resubmission.

**PAYMENT SERVICES**  
Phone 604 276-3085  
Toll-free 1 888 422-2228

**FAX**  
**604 233-9777**  
Toll-free 1 888 922-8807

**MAIL**  
Payment Services, WorkSafeBC  
PO Box 4700 Stn Terminal  
Vancouver BC V6B 1J1

|                            |
|----------------------------|
| Number of pages sent       |
| Service location code<br>Z |

|                          |                 |             |
|--------------------------|-----------------|-------------|
| Invoice date* (yyyymmdd) | Invoice number* | Contract ID |
|--------------------------|-----------------|-------------|

**A. Payment information**

|   |                                       |                     |
|---|---------------------------------------|---------------------|
| Provider name                               | Clinic name*                          | Payee number*       |
| Mailing address for payment                 | City                                  | Province            |
| Telephone number (please include area code) | Fax number (please include area code) | Postal code*        |
|   |                                       | Practitioner number |

**B. Service recipient information (worker or other person who received service)**

|                              |  |   |
|------------------------------|--|---|
| Service recipient last name* | Service recipient first name*            | WorkSafeBC claim number   |
| Date of birth* (yyyymmdd)    | Personal health number (CareCard number) | Gender<br>Female <input type="checkbox"/> Male <input type="checkbox"/> |

**C. Injury information**

|  |                                     |
|--|-------------------------------------|
| Date of injury (yyyymmdd)  | Diagnostic code (ICD-9 code)<br>389 |
| Side of body*<br>Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> Not applicable <input type="checkbox"/> | Body part code*<br>02000            |
|  | Nature of injury code<br>12610      |

**D. Service information**

| Date of service* (yyyymmdd) | Type of service* (see description)                  | Fee item code* | Service details* (make, model, and serial number, as appropriate) | Ear(s)* | Number of units* | Cost per item* (cost per unit) | Line item cost* |
|-----------------------------|---|----------------|---|---------|------------------|--------------------------------|-----------------|
|                             | Fitting fee (requires verification measures)        | 19680          |   |         |                  |                                |                 |
|                             | First-time fitting fee                              | 19681          |   | N/A     |                  |                                |                 |
|                             | In-house service fee                                | 19687          |   |         |                  |                                |                 |
|                             | Out-of-office repair fee                            | 19688          |   |         |                  |                                |                 |
|                             | Manufacturer's repair cost (invoice incl. shipping) | 19698          |   |         |                  |                                |                 |
|                             | Ear impression                                      | 19691          |   |         |                  |                                |                 |
|                             | Ear mold cost (invoice incl. shipping)              | 19699          |   |         |                  |                                |                 |
|                             | Accessories   | 19693          |   |         |                  |                                |                 |
|                             | First-time fitting (6-month follow-up)              | 19625          |   | N/A     |                  |                                |                 |

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**Total invoice amount\* \$**



**RESET**

## HEARING AID PROGRAM COVER SHEET

Fax to: WorkSafeBC  
604 233-9777  
Toll-free 1 888 922-8807

For further information regarding the use of this cover sheet, please contact Health Care Services at 604 232-7787 or toll-free 1 888 967-5377, ext. 7787.

### Worker information

|                  |            |                |                         |
|------------------|------------|----------------|-------------------------|
| Worker last name | First name | Middle initial | WorkSafeBC claim number |
|------------------|------------|----------------|-------------------------|

### Provider information

|                                     |   |
|-------------------------------------|---|
| Company/provider name               | Provider phone number <i>(please include area code)</i> |
| Provider mailing address            | Payee number <i>(vendor number)</i>                     |
|                                     | Submission date <i>(yyyy-mm-dd)</i>                     |
| Date of service <i>(yyyy-mm-dd)</i> |   |

### Type of report

- Audiogram  Real ear measurements  
 Manufacturer's invoice — please stamp on invoice "COPY ONLY, NOT FOR PROCESSING"  
 Photocopy  Other *(please specify)*

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**INDEXERS:** Please index any report(s) submitted with this cover sheet as 83D110. Copies of these reports as submitted with this cover sheet are required as "proof" for payment processing.

