

Once completed, please return to:

Head of Service Audiology

**APPEAL AGAINST THE CHARGE FOR THE REPLACEMENT OF A LOST HEARING AID(S)**

<b>DETAILS</b>	<b>Name:</b>
	<b>Address:</b>
	<b>Postcode:</b>
<b>AUDIOLOGIST SUMMARY</b>	
	<b>Dates of Previous Losses:</b>
	<b>Summary of Appointment:</b>
<b>PATIENT SUMMARY:</b>	
	<b>Audiologist Signature:</b>
	<b>Please explain the circumstances surrounding the loss of your hearing aid(s) in as much detail as possible, together with your reasons for appealing against the charge to replace the instrument.</b>
<b>DECLARATION BY CLAIMANT:</b>	
	<b>I certify that the information above is a true and correct statement</b>
	<b>Name (Print):</b>
	<b>Signed:</b>
	<b>Date:</b>