ACOUSTICIANS GAZETTE 2026

HEARING AID ACOUSTICIANS (PRACTICE 083)		
General Rules		
Rule	**Rule Description**	
001	Pre-Authorisation is required for all hearing aid services	
002	A request for hearing aids must be accompaned by a referral letter from the treating medical practitioner.	
003	Motivation from the treating medical practitioner will be required for renewal of hearing aids.	
004	Unless timely steps are taken (at least two hours) to cancel an appointment for a consultation the relevant consultation fee shall be payable by the employee.	
005	The fee in respect of more than one evaluation shall be the full fee for the first evaluation plus half the fee in respect of each additional evaluation, but under no circumstances may fees be charged for more than three evaluations carried out.	
Tariff Codes		
Code	**Code Description**	**Rand**
83001	First consultation (comprehensive) Units for report writing included in the tariff code	**575.85**
83003	Follow up and final consultation Units for report writing included in the tariff code	**504.03**
83021	Test - air conduction	**126.01**
83023	Test - bone conduction	**126.01**
83025	Test - speech hearing tests	**176.41**
83027	Test - free field	**161.29**
83029	Test - insertion gain (per ear)	**137.35**
83031	Test - binaural loudness balance test, per ear	**161.29**
83051	Global charge for supply and fitting of hearing aid and follow-up. Refer to Rule 001 No other tariff code can be billed with tariff code 83051	**-**
83053	Hearing Aid Evaluation, per ear (refer to General Rule 005)	**161.29**
83055	Technical adjustment or replacement of earmolds	**265.87**
83057	Repairs/service per instrument (5X services/ 5 year cycle)	**-**
83059	Tympanogram	**126.01**
83061	Reflex test (stapedial reflex)	**126.01**

ANNEXURE A: FIRST SPEECH THERAPY REPORT

1. AUTHORISATION REQUEST FORM			
Please indicate your request type with an X:			
First speech therapy report		Extension of treatment period required	
Additional treatment sessions required		Amendment to treatment codes required	
INJURED EMPLPOYEE DETAILS			
Surname:			
First Names:			
Identity Number:			
Telephone number:			
Address: Postal code:			
EMPLOYER DETAILS			
Name of Employer:			
Telephone number:			
Date of Injury / Onset of symptoms:			
REFERRING DOCTOR DETAILS			
Referring Doctor:			
Telephone Number:			
Email address:			
Referring Doctor Practice Number			
Dated referral letter stipulating reason for the referral and referring doctor stamp and signature has been included with this authorisation request:	YES	NO	
SUPPORTING DOCUMENTS ATTACHED TO AUTHORISATION REQUEST ONLY IF CLAIM NOT REGISTERED			
Please indicate attached documents with an X (only attach if necessary):			
WCL2		WCL4		ID	
INJURY / SYMPTOM DETAILS			
ICD 10 Code:			
Diagnosis:			

CURRENT PRESENTATION:

SPEECH THERAPY / AUDIOLOGY REHABILITATION PLAN	
A. SPEECH THERAPY / AUDIOLOGY REHABILITATION PLAN	
Ensure that the treatment goals are specific and measurable with outcome measurements.	
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B. ANTICIPATED DURATION AND FREQUENCY OF TREATMENT INCLUDE DATES	
Overall expected duration of treatment intervention:	
Overall expected number of treatment sessions:	
Frequency of treatment intervention (daily; bi-daily; weekly etc):	

C. ANTICIPATED CODING FOR ABOVE TREATMENT SESSIONS			
CODE:	**QUANTITY**	**CODE:**	**QUANTITY**

MOTIVATION FOR CHANGE IN AUTHORISATION REQUEST (COMPLETE ONLY IF NOT THE FIRST SPEECH THERAPY / AUDIOLOGY REHABILITATION REPORT)

SERVICE PROVIDER DETAILS	
Name:	
Practice Number:	
Date of initial consultation:	
Date of pre-authorisation request:	
Telephone Number:	
Email address:	
Signature:	

ANNEXURE B: MONTHLY / INTERIM SPEECH THERAPY REHABILITATION REPORT

Speech Therapy / Audiology Rehabilitation Progress/Interim Monthly Report
Compensation for Occupational Injuries and Disease Act

Name and Surname of Employee:	
Identity Number:	**Address:**
	Postal Code:
Name of Employer:	
Address:	
	Postal Code:
Date of Accident:	
1. Date of First Treatment:	**Provider of First Treatment:**
2. Name of Referring Medical Practitioner:	**Date of Referral:**
3. Number of Sessions already delivered:	
4. Progress achieved (including outcome measures e.g. Swallowing ability, language ability)	
5. Did the patient undergo surgical procedures in this time? Dates and type of surgery	
6. Number of sessions required:	
7. Treatment plan for proposed treatment sessions:	
8. From what date has the employee been fit for his/her normal/ light work? (Please circle where applicable)	
I certify that I have by examination, satisfied myself that the injury(ies) are as a result of the accident.	
Signature of service provider:	**Date:**
Name:	
Practice Number:	
NB: Speech Therapy / Audiology Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts	

ANNEXURE C: FINAL SPEECH THERAPY REHABILITATION REPORT

Final Report	
Compensation for Occupational Injuries and Disease Act	
Name and Surname of Employee:	**Address:**
Identity Number:	
Postal Code:	
Name of Employer:	
Address:	
Postal Code:	
Date of Accident:	
Date of First Treatment:	**Provider of First Treatment:**
Name of Referring Medical Practitioner:	**Date of Referral:**
1. Number of Sessions already delivered: From_____ To_____	
2. Progress achieved (including outcome measures e.g. Swallowing ability, language ability):	
3. Did the patient undergo surgical procedures in this time? Dates and type of surgery.	
4. From what date has the employee been fit for his/her normal work?	
5. Is the employee fully rehabilitated/has the employee obtained the highest level of function?	

6. If so, describe in detail any present permanent anatomical effect and/or impairment of function as a result of the accident (e.g. swallowing ability language ability)	
I certify that I have by examination, satisfied myself that the injury(ies) are as a result of the accident.	
Signature of service provider:	**Date:**
Name:	
Address:	**Post Code:**
Practice Number:	
NB: Speech Therapy / Audiology Rehabilitation progress reports must be submitted on a monthly basis and attached to the submitted accounts	