haapi hearing aid assistance program of indiana

Order Modification Form

Date: _____

Please complete this form to modify orders for hearing aids, accessories, and earmolds.

Patient Information

Name: _____ DOB: _____ PO #: _____

Audiologist Information

Name: _____ Clinic: _____

Original Order Information

☐ I am exchanging these devices within the manufacturer return window. I understand that if I am outside this window I may be responsible for any additional charges that accrue.

Invoice Date: _____ Fit Date: _____

Reason For Change

_____

_____

_____

New Order Information

Please include new hearing aid, earmold or accessory information below.

_____

_____

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