



CCHAT

PROVIDER APPLICATION TO BE COMPLETED BY THE DISPENSING AUDIOLOGIST

Form is to be submitted only once to become a CCHAT provider.

Name of Audiologist: _____ Ohio License #: _____
Name of Practice: _____ Work Phone#: _____
Address of Practice: _____
City and Zip Code: _____
Email Address: _____
BCMh Approved: Yes No Medicaid Approved: Yes No

- 1) Are you experienced in fitting children/ infants with hearing aid amplification? Yes No
- 2) How many children/ infants have you fit with hearing aids in the past year? _____
- 3) What brand of hearing aid do you typically prescribe for children/ infants? _____
- 4) Please describe your follow up procedures when fitting hearing aid on children/ infants? _____

Upon acceptance as a hearing aid provider for the CCHAT Program, you agree to the following terms:

- a) To recommend and fit the optimum amplification that is most appropriate for each child or infant seeking funds through CCHAT.
- b) To schedule all eligible children/infants as soon as possible to expedite fitting of hearing aid amplification.
- c) If patient is approved by either BCMH or Medicaid, you as the dispensing audiologist agree to forward any funds in the amount specified by CCHAT to CCHAT to cover the funds previously forwarded; if applicable.
- d) If BCMH or Medicaid funds are authorized for your patient, your account will be forwarded the bill, therefore, you agree to take on the billing responsibilities supplied by either Oticon or Phonak.
- e) To return the hearing aid(s) purchased by CCHAT to CCHAT if a patient is no longer in need of the hearing aids. The hearing aids will be used as loaners for other children.
- f) To notify CCHAT Coordinator immediately if a change in any information occurs and/or you receive any additional information regarding your child's BCMH/Medicaid approval/denial status.

If you agree with the above terms, please sign and date. Your name will be updated in our provider list for the Cincinnati Children's Hearing Aid Trust.

Signature of Provider: _____ Date: _____

*****After completing form entirely, please save a copy as "(YOUR First and Last Name) Provider Application". Example: Cali Allen's Provider Application. Attach document in e-mail and send to: Cali.Allen@cchmc.org. If you have any questions please contact: Cali Allen at 513-636-CHAT (2428). Form can also be faxed to: 513-636-8133 ATTN: Cali Allen or mailed to: Cincinnati Children's Hospital Medical Center, ATTN: Cali Allen, 3333 Burnet Avenue, MLC 2018, Cincinnati, OH 45229-3039.*****

The Cincinnati Children's Hearing Aid Trust reserves the right to change the eligibility criteria at any time without written notification. The program will provide funding for hearing aid amplification as long as the funds for the program are available.