



CCHAT

Hearing Aid Request Form

Audiologist's Name: _____ **Name of Practice:** _____
Practice Street Address: _____ **City/St/Zip:** _____ **County:** _____
Email: _____ **Phone:** _____ **Fax:** _____
Are you currently a CCHAT Provider? Yes If not, please submit a Provider Application.

Managing Physician's Name: _____ **Name of Practice:** _____
Practice Street Address: _____ **City/State/Zip:** _____ **County:** _____
Email: _____ **Phone:** _____ **Fax:** _____
Last ENT Visit: _____

Parent/Guardian Information

Parent Name(s): _____ ****Email:** _____
Parent Address: _____ **City/State/Zip:** _____ **County:** _____
Home #: _____ **Cell #:** _____ **Work #:** _____ **Fax #:** _____

Patient Information

Patient Name: _____ **Date of Birth:** _____ ***MRN#:** _____
Guardian: _____ **Does your child have hearing aids currently?** Yes No
When was the loss identified? Explain: _____
Pre-existing Medicaid Patient? No Yes, if so, Medicaid Number: _____ Please attach copy of Medicaid Card

Hearing Loss

Results of Newborn Hearing Screening: *Right Ear:* Pass Refer
Left Ear: Pass Refer
Etiology of Hearing Loss: _____
Please describe any family history of hearing loss: _____
In which ear is a hearing device being requested: Left Right Both
Has child been fit with amplification on a trial basis? Yes No

Testing

Please include a copy of the current audiogram taken within 6 months, physiologic test results, physician visit forms and any other pertinent audiological information needed for diagnosis with this request.

Anything else we should know?

Hearing Aids

We provide hearing aids from Oticon and Phonak. All aids also come with a Patient Care Kit. Please select your model preference:

Oticon Account #: _____ PO# _____

SAFARI: 300 300 POWER 300 SUPER POWER

Phonak Account #: _____ PO #: _____

CASSIA: MICRO M MICRO P SP PETITE
CERTENA ART: M P SP MICRO PETITE
NAIDA: III UP DAZ III SP DAZ S III SP S III UP
NIOS: MICRO III
MILO PLUS: SP UP MICRO
OK! PLUS: SP UP M

COLOR: _____ BATTERY SIZE: _____ TP DOORS: YES NO PEDIATRIC EAR HOOKS: YES NO

Contact information to where hearing aid(s) should be delivered:

Name: _____

Address: Same practice as above; if not: _____

By printing your name below, you affirm that the information contained within this application is current and complete. If a change in any information occurs, please notify CCHAT immediately. Additionally, I grant permission to the Cincinnati Children's Hearing Aid Trust to release all medical records pertaining to my patient's hearing disorders to the assigned CCHAT Coordinator for the purposes of applying for alternative financial assistance.

Audiologist Signature: _____ Print: _____ Date: _____

*****After completing form entirely, please save a copy as "(Patient's First and Last Name) CCHAT Request". Example: Cali Rhein's CCHAT Request. Attach document in e-mail and send to: Cali.Rhein@cchmc.org. If you have any questions please contact: Cali Rhein at 513-636-CHAT (2428). Form can also be faxed to: 513-636-8133 ATTN: Cali Rhein or mailed to: Cincinnati Children's Hospital Medical Center, ATTN: Cali Rhein, 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.