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Cincinnati Children's
changing the outcome together

CCHAT

Cincinnati Children's Hearing Aid Trust

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/St/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
Does patient have private insurance? ☐ Yes ☐ No If yes, were they denied coverage? ☐ Yes ☐ No

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
Does child have a PTA of at least 25dB in requested ear(s)? ☐ 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. **Contact CCHAT Coordinator for updated offerings.**
Please select your model preference:

Oticon Ship to Account #: _____

OPN PLAY 2 ☐BTE PP
XCEED PLAY 2 ☐SP ☐UP
PLAY PX 2 ☐MINIBTE R ☐MINIBTE T

Phonak Ship to Account # : _____

SKY M50 ☐ M ☐PR ☐SP
SKY L50 ☐PR ☐M ☐ SP ☐ UP

Color: _____

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 attach document in e-mail and send to: Kelly.Brockman@cchmc.org. If you have any questions please contact: Kelly Brockman at 513-636-CHAT (2428). Form can also be faxed to: 513-636-8133 ATTN: Kelly Brockman

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.