3333 Burnet Avenue • MLC 2018 • Cincinnati, OH • 45229
513-636-CHAT (2428) • www.cincinnatichildrens.org/cchat

Cincinnati Children's
Hearing Aid Trust

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: _____

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 for full or partial assistance through their private insurance, you as the dispensing audiologist agree to notify CCHAT Coordinator and continue to forward any funds in the amount specified by CCHAT to CCHAT to cover the funds previously forwarded; if applicable.
d) 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.
e) To notify CCHAT Coordinator immediately if a change in any information occurs and/or you receive any additional information regarding your patient's BCMH/Medicaid approval/denial status or any other third party funding 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 "(Patient's First and Last Name) CCHAT Request". Example: Kelly Brockman's CCHAT Request. 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 or mailed to: Cincinnati Children's Hospital Medical Center, ATTN: Kelly Brockman, 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.

Updated: 10/2011