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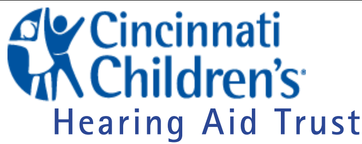

CCHAT

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/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
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, Phonak, and Widex. All aids also come with a Patient Care Kit. Please select your model preference:

Oticon Account #: ____________________ PO#__________________

SAFARI:	☐ 300 SP	☐ 600 SP	☐ 900 SP
SENSEI:	☐312	☐13	
SENSEI PRO:	☐312	☐13	

Phonak Account #: ___________________ PO #:_________________

NAIDAQ50:	☐SP	☐ UP		
BOLERO Q50:	☐ M13	☐M312	☐P	☐SP
SKY Q50	☐ M13	☐SP	☐ UP	

Widex Account #: __________________ PO #:_________________

MIND 220:	☐ 9	☐19	☐MICRO		
CLEAR 220:	☐ 9	☐PASSION	☐MICRO	☐FUSION	☐SUPER, DAI

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 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: 2/2014