



# CCHAT

## Cincinnati Children's Hearing Aid Trust

### CCHMC PROVIDER APPLICATION

#### TO BE COMPLETED BY THE DISPENSING AUDIOLOGIST

Document Locked: Please type information onto lined area followed by tab key or by selecting lined area. If submitting form via e-mail, digital signature will suffice. Form is to be submitted only once to become a CCHAT provider.

Name of Audiologist: \_\_\_\_\_ Ohio License #: \_\_\_\_\_  
Campus: \_\_\_\_\_ Work Phone#: \_\_\_\_\_  
Address of Practice: \_\_\_\_\_  
City and Zip Code: \_\_\_\_\_  
County: \_\_\_\_\_

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 attach document in e-mail and send to: [Kelly.Brockman@cchmc.org](mailto: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.*