Audiologist Registration (Path B)

Please complete this form if you are an audiologist who **contracts with insurance companies**.
Note: Each audiologist who is interested in participating in HAAPI must complete a separate registration form, even if another audiologist within the same facility has already done so.

Audiologist Name: _____

Indiana License Number: _____

Facility Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Audiologist Email: _____

Facility Owner/Director Name: _____

Contact Person: _____

Contact Email (if different than audiologist): _____

Which of the following do you have the software to program?

Traditional Hearing Aids:
☐ Oticon ☐ Phonak ☐ Siemens

Bone Anchored Hearing Aids:
☐ Cochlear ☐ Oticon Medical

Please list the insurance companies with which your facility is credentialed.

_____

_____

_____

Agreement to Participate in HAAPI

As a HAAPI participating audiologist, I agree to the following for my work with all families (with or without insurance coverage):

- ☐ I hold a current **Indiana** licensure in audiology, and will maintain an unrestricted Indiana license at all times while participating in HAAPI
- ☐ I currently have and will maintain professional liability insurance at all times while participating in HAAPI. I understand that all clinical decisions regarding hearing aids and all professional services are my responsibility, and that neither HAAPI nor the HAAPI administrator have any healthcare provider relationship with my patients.
- ☐ I understand that my Participating Audiologist Application and the Facility Registration Forms must be accepted **prior** to submitting my first hearing aid order OR reimbursement through HAAPI.
- ☐ I will assist the family with applying to HAAPI. I understand that the family's application must be approved **prior** to ordering a hearing aid through HAAPI on behalf of a family OR my first reimbursement request. I agree not to order hearing aids under the HAAPI account for any patients who have not been approved.
- ☐ I understand that HAAPI is the payor of last resort.
- ☐ I have reviewed the American Academy of Audiology (AAA) and the American Speech-Language-Hearing Association (ASHA) clinical practice guidelines on pediatric amplification and agree to abide by the audiological best practices listed therein. (A copy of these guidelines is available at HAAPIndiana.org/AAAguidelines.)
- ☐ **I will complete an Audiologist Attestation Form documenting insurance denial (or coverage) of the hearing aid.**
- ☐ I understand that I will not make a profit on the aids/molds obtained through this program.
- ☐ I understand that I CAN bill the patient for follow-up services (e.g., hearing aid adjustments) in accordance with my usual and customary rates. I will explain these fees (if applicable) to the family before ordering the device.
- ☐ **I agree to return aids to manufacturer and/or dispersed funds to HAAPI if the aid is not dispensed or if it is returned for some reason.**

In addition, I agree to the following procedure in cases where my patient has insurance that covers **0%** of the manufacturer price for the hearing aid:

- ☐ I will select the most appropriate hearing aid from the HAAPI approved list.
- ☐ I understand that HAAPI will cover up to $1500 per ear for the hearing aid, which must include the fitting, a 3-year warranty, and an earmold. Depending on which hearing aid is chosen, any cost over $1500 will result in an out-of-pocket cost to the family.

- ☐ I understand that HAAPI will pay me any portion of the fitting fee not covered by insurance (up to $250 per ear), and I agree not to charge the patient more for the fitting.

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Agreement Continued From Previous Page

I addition, I agree to the following procedures in cases where my patient has insurance that covers **SOME** percentage of the manufacturer price for the hearing aid:

- ☐ I will select the most appropriate hearing aid from the approved list after provisional approval has been received from HAAPI administrators.
- ☐ **I will order and pay for the device received from the manufacturer using my contracted pricing with those companies. I will NOT order devices with the HAAPI account number when partial coverage is available.**
- ☐ I will bill insurance on behalf of the family.
- ☐ Once received, I will send the EOB and manufacturer's invoice to HAAPI to determine my reimbursement. HAAPI will pay the difference between any insurance payment and the manufacturer's invoice price (up to $1500 total for the hearing aid and fitting fee combined).
- ☐ **I understand that I may only bill the patient if HAAPI does not cover my full manufacturer's invoice cost. I may not balance bill the patient (attempt to recoup my customary price for selling this device).**

By signing below I am affirming that I agree to the statements above:

_____

Authorized Signature Date

☐ By initialing here I understand that my registration will not be accepted until the following documentation is received:

☐ Valid Indiana license ☐ W-9
☐ Proof of professional liability coverage ☐ E-payments Form

Email, fax, or mail this form and supporting documents to:

Info@HAAPIndiana.org

Fax: 888-897-0932

Questions? Call 317-828-0211

HAAPI
Attn: Hear Indiana, Program Administrator
4740 Kingsway Dr., Ste. 33
Indianapolis, IN 46205

For Administrative Use Only:
Date Received: _____
Date Complete: _____