haapi hearing aid assistance program of indiana

administered by hear indiana

Indiana State Department of Health

Center for Deaf and Hard of Hearing Education

# Form A: Audiologist Registration

Please complete this form if you **do <u>NOT</u> contract with any insurance companies** or any 3rd Party discount program.

*<u>Note</u>: 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?

☐ Oticon ☐ Phonak ☐ Siemens

☐ By initialing here, I attest that my facility does not file insurance or accept 3rd party discount programs. If at any time this changes, it is my responsibility to contact HAAPI and complete a new registration form for participating audiologists who contract with or directly bill insurance companies or third party benefit programs.

☐ 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

**Agreement to Participate in HAAPI**

As a HAAPI participating audiologist who does not accept insurance, I agree to the following:

- ☐ 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 administrators have any healthcare provider relationship with my patients.
- ☐ I understand that my Participating Audiologist Registration Forms must be accepted **prior** to submitting my first hearing aid order 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.
- ☐ I understand that HAAPI is the payor of last resort.
- ☐ I will help the family obtain **written documentation** of denial (or coverage) for each of the following: hearing aid, fitting fee, and earmold.
- ☐ I will inform each family of a school-age child who needs hearing aids about HAAPI.
- ☐ I understand that if a child has any insurance coverage for the hearing aid, earmold, or fitting fee, that the patient must see an audiologist who has the ability to bill and accept insurance payments (not myself) in order to be eligible for secondary coverage through HAAPI.
- ☐ 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 are available at Haapindiana.org/audiologists/guidelines.)
- ☐ I will select the most appropriate hearing aid from the approved list.
- ☐ I understand that HAAPI will order the hearing aid direct from the manufacturer, and that the hearing aid will ship directly to my office. All hearing aids include a 3-year warranty, an earmold, and a pediatric care kit that I agree to pass along to the patient at time of fitting.
- ☐ I agree to accept payment as payment in full, the amount deteremined by the HAAPI administrator, for dispensing and fitting hearing aids to HAAPI participants. I agree not to bill participants, or any member of a participant's family, for any additional charges for fitting and dispensing the hearing aids.
- ☐ I understand that HAAPI will pay $250 (per ear) for the fitting fee and I agree not to charge the patient more if I accept the $250 fee from HAAPI.
- ☐ I understand that I CAN charge the patient for follow-up services (e.g., hearing aid adjustments) in accordance with my usual and customary rates. I will clearly explain these fees (if applicable) to the family before ordering the device.
- ☐ **I agree to return aids to HAAPI if the aid is not dispensed or if it is returned for some reason.**

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

_____

Authorized Signature Date

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

Info@HAAPIndiana.org
Fax: 888-887-0932

**Questions?** Call 317-828-0211

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

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