



INVOICE FORM

REVISED 3.14.22

Applicant's Information

Applicant's Name: _____ DOB: _____

Fitting Audiologist: _____ PO# _____

Billing Information

Make Check Payable to: _____

Billing Office Address: _____

Billing Contact: _____ Phone Number: _____

Email: _____

Note: Please fill out EITHER the initial or follow up section below, not both.

Initial Fitting - Complete at Initial visit

Fitting Date: _____ Unilateral Fitting, \$400 Bilateral Fitting, \$600

Device(s) Fit: _____

Follow-Up - Complete at Annual Visit

Follow-Up Date: _____

Please check all that was completed during the appointment.

Comprehensive audiogram

Aided speech perception testing

Earmold impression(s)/fitting

Hearing aid real-ear verification and reprogramming as necessary

Unilateral Follow-Up, \$250

Bilateral Follow-Up, \$350

Required Documentation:

Datalogging
 _____ hours per day, right device
 _____ hours per day, leftdevice

I've included a copy of the audiogram from the follow-up

Audiologist's Signature

Date

Please send all invoices to accountspayable@haapindiana.org