Hearing Advancement Center

HEARING AID INSURANCE VERIFICATION WORKSHEET

Date: _____

Patient Name: _____ Patient DOB: _____

Insured's Name: _____ Insured's DOB: _____

Insurance Company _____ Policy Number: _____

Representative: _____Reference: _____

☐ Primary ☐ Secondary ☐ Tertiary

Participating Provider: ☐ Yes ☐ No **In-Network Provider:** ☐ Yes ☐ No

What is the allowable benefit? _____ How much of it has been used to date? _____

Is the patient allowed to share in the cost of the device(s) if they choose technology beyond their benefit? ☐ Yes ☐ No

Will a specific type of hearing aid realize their maximum benefit? ☐ Yes ☐ No

If yes, what type? _____

What is the out-of-network benefit? (if out-of-network): _____

Is the hearing aid benefit: ☐ Monaural ☐ Binaural Every: ☐ 2 years ☐ 3 years ☐ 5 years

Is benefit applied to usual and customary or allowed amount? ☐ Yes ☐ No

Anticipated write-off: $_____

Is a provider discount required? ☐ Yes ☐ No

If yes, what is the amount of the discount? _____

Patient Responsibility Deductible: _____ When was it met? _____

Co-Pay _____ Co-Insurance _____

Plan Requirements (check if required) ☐ Prior Authorization ☐ Medicare Denial ☐ Referral ☐ Prescription
☐ Medical Clearance ENT Only? Y/N ☐ Actual Invoice Required ☐ Other: _____

Codes to be billed are they covered? If not, how are uncovered codes handled?

Hearing Aid Code(s): _____

Professional Fee Code(s): _____

V5264 Earmold (per unit) V5275 Ear Impression (per unit) V5010 Assessment for Hearing Aid Other:

_____

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