

	P	RACTICE IN	IFORMATION		
Legal Business Name (as ap	pears on the	: W-9):			
DBA:					
Practice Type (Please circle Other:	one): Incorp	oorated LLC PL	LC Partnership Sole	Proprietor	
State of Incorporation:			Federal Tax ID:		
What Hearing Aid Manufact	urers do you	work with? (plea	ase check mark all th	at apply)	
■ Resound	■ Beltone	•	☐ Starkey		Phonak
Ship to Acct #	Dispenser #		Ship to Acct #	Sh	ip to Acct #
□ Oticon	☐ Unitron	1	□ Widex		3 Signia
Ship to Acct #	Ship to Acct	#	Ship to Acct #	Sh	ip to Acct #
Type 2 NPI (Location NPI):			Number of Service	Locations:	
Address for Notice:					
City:		State:		ZIP Code:	
County:		Phone:		Fax:	
Owner E-mail:					
	OW	/NERSHIP I	NFORMATION		
Owner Name (Last, First):				Ownership F	Percentage:
Does this practice have any	additional o	wners? (Please c	ircle one) Yes No		
If yes, please list below:					
Owner 2 Name (Last, First):			(Ownership F	Percentage:
Owner 3 Name (Last, First):			(Ownership F	Percentage:
	SERVI	CE LOCATIO	ON INFORMAT	ION	
		LOCAT	TION 1		
Location Name:					
Address:					
City:		State:		ZIP Code:	
County:	P	hone:		Fax:	
Location E-mail:					
Office Contact Name:		Office Contact Title:			
Office Contact Phone: Office Contact				t E-mail:	
Public Transportation Route	Available?	(Please circle one	e) Yes No		
Wheelchair Access? (Please	circle one):	Yes No	Pediatric Services?	(Please circ	ele one): Yes No
ADA Compliant? (<i>Please sel</i>	ect one): Yo	es No	Does this location a one): Yes No	ccept new p	patients? (<i>Please select</i>
Sound field speakers, sound one): Yes No	proof booth	or sound treated	l room available and	regularly ca	librated (<i>please select</i>
Hours of Operation: Monday		Tuesd	ay:	Wedne	esday:
Thursday: Fric	lay:	Satu	ırday:	Sunday	<i>r</i> :



Languages Spoken:					
Public Transportation Route Available	? (Please circle one	Yes No			
Additional Services Offered at this loca	ation (Please check	mark ALL that app	ly):		
ADP Testing	ENG\VNG	i	OAEs		
ADP Treatment	Tympanor	metry	VRA		
Conditioning Play Audiometry	ABR		Aural Rehabilitation		
Tinnitus Evaluations	CI		BAHA\Osteo Integrated Devices		
ECoG	Rotary Ch	air	Posturography		
	LOCAT	TION 2			
Location Name:	LOCAL	1011 2			
Address:					
City:	State:		ZIP Code:		
County:	Phone:		Fax:		
Location E-mail:					
Office Contact Name: Office Contact Title:			e:		
Office Contact Phone:		Office Contact E-mail:			
Wheelchair Access? (Please circle one): Yes No Pediatric Services? (Please circle one): Yes No					
ADA Compliant? (Please select one):	Yes No	Does this location (Please select one	accept new patients?): Yes No		
Sound field speakers, sound proof boo (please select one): Yes No	th or sound treated	l room available an	d regularly calibrated		
Hours of Operation: Monday:	Tuesda	ay:	Wednesday:		
Thursday: Friday:	Satu	ırday:	Sunday:		
Languages Spoken:					
Public Transportation Route Available? (Please circle one) Yes No					
Additional Services Offered at this location (Please check mark ALL that apply):					
ADP Testing	ENG\VNG		OAEs		
ADP Treatment	Tympanometry		VRA		
Conditioning Play Audiometry	ABR		Aural Rehabilitation		
Tinnitus Evaluations	CI		BAHA\Osteo Integrated Devices		
ECoG	Rotary Chair		Posturography		
	LOCAT	TION 3			
Location Name:					
Address:					
City:	State:		ZIP Code:		
County:	Phone:		Fax:		
Location E-mail:					



Wheelchair Access? (Please circle one): Yes No ADA Compliant? (Please select one): Yes No Does this location accept new patients? (Please select one): Yes No Sound field speakers, sound proof booth or sound treated room available and regularly calibrated (please select one): Yes No Hours of Operation: Monday: Tuesday: Friday: Saturday: Saturday: Sunday: Languages Spoken: Public Transportation Route Available? (Please circle one) Yes No Additional Services Offered at this location (Please circle one) Yes No Additional Services Offered at this location (Please check mark ALL that apply): ADP Treating ENG/VNG OAES ADP Treatment Tympanometry VRA Conditioning Play Audiometry ABR Aural Rehabilitation BAHA\Osteo Integrated Devices ECOG Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Title:	Office Contact Name:		Office Contact Title	e:		
ADA Compliant? (Please select one): Yes No Does this location accept new patients? (Please select one): Yes No Sound field speakers, sound proof booth or sound treated room available and regularly calibrated (please select one): Yes No Hours of Operation: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday: Sunday: Languages Spoken: Public Transportation Route Available? (Please circle one) Yes No Additional Services Offered at this location (Please check mark ALL that apply): ADP Testing ENG\VNG OAEs ADP Treatment Tympanometry VRA Conditioning Play Audiometry ABR Aural Rehabilitation Tinnitus Evaluations CI BAHA\Osteo Integrated Devices ECOG Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name:	Office Contact Phone:		Office Contact E-m	ail:		
ADA Compliant? (Please select one): Yes No Sound field speakers, sound proof booth or sound treated room available and regularly calibrated (please select one): Yes No Hours of Operation: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday: Languages Spoken: Public Transportation Route Available? (Please circle one) Yes No Additional Services Offered at this location (Please check mark ALL that apply): ADP Testing ENG\VNG OAES ADP Treatment Tympanometry VRA Conditioning Play Audiometry ABR Aural Rehabilitation Tinnitus Evaluations CI BAHA\Osteo Integrated Devices ECOG Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name:	Wheelchair Access? (Please circle one): Yes No	Pediatric Services? (Please circle one): Yes No			
Conditioning Play Audiometry Conditioning Play Audiometry Conditioning Play Audiometry Condition Name: County: Cou	ADA Compliant? (Please select one):	Yes No		•		
Thursday: Friday: Saturday: Sunday: Languages Spoken: Public Transportation Route Available? (Please circle one) Yes No Additional Services Offered at this location (Please check mark ALL that apply): ADP Testing ENG\VNG OAEs ADP Treatment Tympanometry VRA Conditioning Play Audiometry ABR Aural Rehabilitation Tinnitus Evaluations CI BAHA\Osteo Integrated Devices ECOG Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name:		th or sound treated	l room available and	l regularly calibrated		
Languages Spoken: Public Transportation Route Available? (Please circle one) Yes No Additional Services Offered at this location (Please check mark ALL that apply): ADP Testing ENG\VNG OAEs ADP Treatment Tympanometry VRA Conditioning Play Audiometry ABR Aural Rehabilitation Tinnitus Evaluations CI BAHA\Osteo Integrated Devices ECOG Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name:	Hours of Operation: Monday:	Tuesda	ay:	Wednesday:		
Public Transportation Route Available? (Please circle one) Yes No Additional Services Offered at this location (Please check mark ALL that apply): ADP Testing ENG\VNG OAEs ADP Treatment Tympanometry VRA Conditioning Play Audiometry ABR Aural Rehabilitation Tinnitus Evaluations CI BAHA\Osteo Integrated Devices ECOG Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name:	Thursday: Friday:	Satu	ırday:	Sunday:		
Additional Services Offered at this location (Please check mark ALL that apply): ADP Testing ENG\VNG OAES ADP Treatment Tympanometry VRA Conditioning Play Audiometry ABR Aural Rehabilitation Tinnitus Evaluations CI BAHA\Osteo Integrated Devices ECOG Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name:	Languages Spoken:					
ADP Testing	Public Transportation Route Available? (Please circle one) Yes No					
ADP Treatment Tympanometry VRA Conditioning Play Audiometry ABR Aural Rehabilitation Tinnitus Evaluations CI BAHA\Osteo Integrated Devices ECoG Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name:	Additional Services Offered at this local	ation <i>(Please check</i>	mark ALL that appl	(y):		
Conditioning Play Audiometry ABR Aural Rehabilitation Tinnitus Evaluations CI BAHA\Osteo Integrated Devices ECOG Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name:	ADP Testing	ENG\VNG		OAEs		
Tinnitus Evaluations CI BAHA\Osteo Integrated Devices Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name:	ADP Treatment	Tympanom	netry	☐ VRA		
ECOG Rotary Chair Posturography LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name: Office Contact Title:	Conditioning Play Audiometry	ABR		Aural Rehabilitation		
LOCATION 4 Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name: Office Contact Title:	Tinnitus Evaluations	CI		BAHA\Osteo Integrated Devices		
Location Name: Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name: Office Contact Title:	ECoG	Rotary Cha	iir	Posturography		
Address: City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name: Office Contact Title:		LOCAT	TON 4			
City: State: ZIP Code: County: Phone: Fax: Location E-mail: Office Contact Name: Office Contact Title:	Location Name:					
County: Phone: Fax: Location E-mail: Office Contact Name: Office Contact Title:	Address:					
Location E-mail: Office Contact Name: Office Contact Title:	City:	State:		ZIP Code:		
Office Contact Name: Office Contact Title:	County:	Phone:		Fax:		
	Location E-mail:					
Office Contact Phone: Office Contact E-mail:	Office Contact Name:		Office Contact Title	e:		
	Office Contact Phone:		Office Contact E-mail:			
Wheelchair Access? (Please circle one): Yes No Pediatric Services? (Please circle one): Yes No	Wheelchair Access? (Please circle one): Yes No		Pediatric Services? (Please circle one): Yes No			
ADA Compliant? (Please select one): Yes No Does this location accept new patients?	ADA Compliant? (Please select one): Yes No		Does this location accept new patients? (Please select one): Yes No			
(Please Select Offe): Tes NO	Sound field speakers, sound proof boo (please select one): Yes No	th or sound treated	l room available and	l regularly calibrated		
Sound field speakers, sound proof booth or sound treated room available and regularly calibrated	Hours of Operation: Monday:	Tuesda	ay: Wednesday:			
Sound field speakers, sound proof booth or sound treated room available and regularly calibrated (please select one): Yes No	Thursday: Friday:	Satu	ırday: Sunday:			
Sound field speakers, sound proof booth or sound treated room available and regularly calibrated (please select one): Yes No Hours of Operation: Monday: Tuesday: Wednesday:						
Sound field speakers, sound proof booth or sound treated room available and regularly calibrated (please select one): Yes No Hours of Operation: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:	Languages Spoken:		iliudy.			
Sound field speakers, sound proof booth or sound treated room available and regularly calibrated	······································	Tuesd	2V'	Wednesday		
Sound field speakers, sound proof booth or sound treated room available and regularly calibrated (please select one): Yes No			<u> </u>			
Sound field speakers, sound proof booth or sound treated room available and regularly calibrated (please select one): Yes No Hours of Operation: Monday: Tuesday: Wednesday:	Thursday: Friday: Saturday: Sunday:					
Sound field speakers, sound proof booth or sound treated room available and regularly calibrated (please select one): Yes No Hours of Operation: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:	Languages Spoken:	Satu	ii day.			
Sound field speakers, sound proof booth or sound treated room available and regularly calibrated (please select one): Yes No Hours of Operation: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:			·			



Additional Services Offered at this locati	on <i>(Please check</i>	mark ALL that apply):	•
ADP Testing	ENG\VNG		OAEs
ADP Treatment	Tympanom	etry	VRA
Conditioning Play Audiometry	ABR		Aural Rehabilitation
Tinnitus Evaluations	CI		BAHA\Osteo Integrated Devices
ECoG	Rotary Cha	ir	Posturography
	LOCAT	TON 5	
Location Name:			
Address:			
City:	State:		ZIP Code:
Phone:		Fax:	
Location E-mail:			
Office Contact Name:		Office Contact Title:	
Office Contact Phone:		Office Contact E-mail	l:
Wheelchair Access? (Please circle one): Yes No		Pediatric Services? (Please circle one): Yes No
ADA Compliant? (Please select one): You	es No	Does this location ac (Please select one):	cept new patients? Yes No
Sound field speakers, sound proof booth (please select one): Yes No	or sound treated	l room available and re	egularly calibrated
Hours of Operation: Monday:	Tuesda	ay:	Wednesday:
Thursday: Friday:	Satu	ırday:	Sunday:
Languages Spoken:			
Public Transportation Route Available?	(Please circle one	Yes No	
Additional Services Offered at this locati	on <i>(Please check</i>	mark ALL that apply):	!
ADP Testing	ENG\VNG		OAEs
ADP Treatment	Tympanom	etry	VRA
Conditioning Play Audiometry	ABR		Aural Rehabilitation
Tinnitus Evaluations	CI		BAHA\Osteo Integrated Devices
ECoG	Rotary Cha	ir	Posturography
HEARING CA	RE PROFES	SIONAL INFOR	RMATION
TOTAL NUMBER OF HEARING CARE PRO	FESSIONALS (HC	P) IN PRACTICE:	
HCP 1 NAME (LAST, FIRST):			
Individual NPI:		CAQH ID:	
Medicare ID:		Medicaid ID:	
Credentials (Please circle one): AuD	MA/MS HIS HA	AS HAD Other:	
Gender:		Languages Spoken:	



Phone:				E-mail:			
Total Number of Locations Assigned:							
Please check mark all	locations assig	ned to H	CP from the	list above			
☐ Location 1	☐ Location	2	☐ Locatio	on 3			
HCP 2 NAME (LAST, FI	RST):						
Individual NPI:				CAQH ID:			
Medicare ID:				Medicaid I	D:		
Credentials (Please cit	rcle one): AuD	MA/M	IS HIS H	AS HAD	Other:		
Gender:				Languages	Spoken:		
Phone:				E-mail:			
Total Number of Locat	ions Assigned:						
Please check mark all locations assigned to HCP from the list above							
☐ Location 1	☐ Location	2	☐ Location	n 3	☐ Location 4	☐ Location 5	
HCP 3 NAME (LAST, FI	RST):						
Individual NPI:				CAQH ID:			
Medicare ID:				Medicaid I	D:		
Credentials (Please cir	<i>rcle one):</i> AuD	MA/M	IS HIS H	AS HAD	Other:		
Gender:				Languages Spoken:			
Phone:				E-mail:			
Total Number of Locat	ions Assigned:						
Please check mark all	locations assig	ned to H	CP from the	list above			
☐ Location 1	☐ Location	2	☐ Locatio	n 3	☐ Location 4	☐ Location 5	
HCP 4 NAME (LAST, FI	RST):						
Individual NPI:				CAQH ID:			
Medicare ID:				Medicaid I	D:		
Credentials (Please cit	Credentials (Please circle one): AuD MA/MS HIS HA			AS HAD	Other:		
Gender:				Languages	Spoken:		
Phone:				E-mail:			
Total Number of Locations Assigned:							
Please check mark all locations assigned to HCP from the list above							
☐ Location 1	☐ Location	2	☐ Locatio	n 3	☐ Location 4	□ Location 5	
HCP 5 NAME (LAST, FIRST):							
Individual NPI:			CAQH ID:				
Medicare ID:				Medicaid ID:			
Credentials (Please cit	rcle one): AuD	MA/M	IS HIS HA	AS HAD Other:			
Gender:				Languages	Spoken:		
Phone:				E-mail:			
Total Number of Locations Assigned:							



Please check mark all	locations assigned to H	CD from the	list above		
Location 1	Location 2	Locatio		☐ Location 4	☐ Location 5
HCP 6 NAME (LAST, FI		Locatio	лі Э	Location 4	L ocation 5
Individual NPI:	1.		CAOH ID.		
			CAQH ID:	D.	
Medicare ID:		IC LITC LI	Medicaid I		
Credentials (Please cir	rcle one): AuD MA/M	S HIS H	AS HAD	Other:	
Gender: Phone:			Languages E-mail:	s эрокеп:	
1	tions Assignad		E-Mail:		
Total Number of Locat	locations assigned to H	CD from the	list above		
Location 1	Location 2	Locatio		☐ Location 4	☐ Location 5
		Locatio	л 3	Location 4	Location 5
HCP 7 NAME (LAST, FI	ik51):		CAOU TD:		
Individual NPI:			CAQH ID:	D.	
Medicare ID:	rele engly AuD MA/M	S HIS H	Medicaid I		
Credentials (Please circle one): AuD MA/MS HIS HAS HAD Other: Languages Spoken:					
Phone:			E-mail:		
	tions Assignad		E-Man:		
Total Number of Locations Assigned: Please check mark all locations assigned to HCP from the list above					
Location 1	□ Location 2 □ Location 3 □ Location 4 □ Location 5				□ Location F
Location 1					Location 5
OWNER ATTESTATION					
1. Is your current busi one):	iness compliant with all	current HI	PAA/HITECH	I rules and regulations?	(Please check mark
	□ N/A				
Yes No	N/A				
2. Has your current business ever been subject to fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? (<i>Please check mark one</i>):					
Yes No	O N/A				
3. Has your current business ever been refused participation from, not renewed or terminated for cause, from participation, or been subject to disciplinary action, by any managed care or provider organizations (including HMOs, PPOs, IPAs or PHOs)? (<i>Please check mark one</i>):					
Yes No	□ N/A				



4. Has your current business ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted from participation in federal or state government healthcare plans or programs including Medicare or Medicaid? (<i>Please check mark one</i>):
Yes No N/A
5. Have you ever had any professional liability actions settled, arbitrated, mediated or litigated? (<i>Please check mark one</i>):
Yes No N/A
6. Has your general or professional business liability coverage ever been cancelled, restricted, declined or not renewed by a carrier based on your liability history? (<i>Please check mark one</i>):
Yes No N/A
7. Has the business owner(s) ever been convicted of or pled guilty to a felony? (<i>Please check mark one</i>):
Yes No N/A
8. Has your business license ever been voluntarily or involuntarily relinquished, denied, suspended, revoked or restricted? (<i>Please check mark one</i>):
Yes No N/A
I acknowledge that if I answered "Yes" to any of the previous attestation questions with the exemption of question # 1, I must provide a detailed written explanation and any supporting documents which should be uploaded with this application.
Printed Name