



## **5.0 Forms and Agreements**

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## **5.1 Prior Authorization Packets**

## Discount Plan Patient Letter

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“Date”

“Patient Name”

“Patient Address”

Dear Patient Name:

Thank you for contacting HearPO to access your discount plan membership hearing benefit. We look forward to working with you. I have enclosed your HearPO Prior Authorization Form that you will present to the hearing provider. This will identify you as an authorized member of your discount plan.

The important things for you to be aware of during this process are:

Now that you have received this packet, please feel free to contact your hearing care provider to set up your appointment. When setting up your appointment, please tell the practice you are being referred to them by HearPO.

- If it is determined that you are a candidate for hearing aids, HearPO brand hearing aids will be available; our quality product line includes all styles and technology levels of hearing aids including the most advanced digital technology.
- Payment in full is due at the time services are rendered and/or hearing aids are dispensed. HearPO accepts checks, VISA, Mastercard, American Express, and Discover.
- Payments for diagnostic testing are made directly to the practice or audiologist at the time of service.
- Payments for hearing aids are made directly to HearPO. If you are asked to purchase hearing aids directly through the practice, please notify HearPO immediately. Payment includes hearing aids, impression, earmold (when applicable) and 1 year of service from provider.
- Hearing aids may be returned within the 60-day adjustment period for a full refund.

HearPO is committed to your satisfaction and quality hearing healthcare. If you have any questions, comments, or concerns during this process, please do not hesitate to contact us at 1-888-HEARING (1-888-432-7464). We would be happy to assist you in any way possible.

Sincerely,

HearPO Customer Service

## Discount Plan Provider Letter

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“Date”

“Provider”

“Provider Address”

Dear Provider:

Enclosed you will find the HearPO Prior Authorization Form for “Patient”. “Patient” is a member of the \_\_\_\_\_ discount plan and has activated her hearing benefit through HearPO. Plan details for \_\_\_\_\_ have been included in this mailing. It is extremely important to review this information prior to seeing the patient.

The following is a list of key items to remember when seeing this patient.

- The patient pays you directly for all negotiated diagnostic services (see plan fee schedule). You retain 100% of the funds collected for diagnostic services.
- Only HearPO brand hearing aids can be recommended and dispensed to this patient. The attached hearing aid spreadsheet outlines approved instruments and the amount charged (TPP) to the patient.
- The patient must pay 100% of the TPP at the time the hearing aids are dispensed. Payment to HearPO may be made via check or credit card and must be forwarded to HearPO with the prior authorization form within 24 hours of dispensing the hearing aid. Checks should be made payable to HearPO.
- Hearing aid orders go directly to the manufacturer using the appropriate HearPO bill-to number and your clinic’s ship-to information. Please reference the Authorization Number located on the enclosed HearPO Prior-Authorization form. HearPO pays the manufacturer for hearing aids and earmolds under this plan.
- You will be reimbursed 60 days after the completed authorization form and payment are received at HearPO.

If you have any questions, please call me directly at 1-800-920-4327.

Sincerely,

Carrie Browning, AuD.  
Director of Professional Relations



**HearPO  
Prior-Authorization Form  
For "Discount Plan"**

**613990**

9/15/06

<b>Patient Information</b>	<b>Provider Information</b>
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"Patient"  
"Patient Address"

"Provider"  
"Provider Address"

<b>Hearing Aids &amp; Diagnostic Services</b>	
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**Hearing Aids(s) Dispensed** HearPO brand hearing aids must be dispensed for this patient. For detailed pricing, including hearing aid caodes, please refer to the HearPO Discount Price Guide.

**LEFT** Hearing Aid code: \_\_\_\_\_  
Style: \_\_\_\_\_ Model: \_\_\_\_\_

**RIGHT** Hearing Aid Code: \_\_\_\_\_  
Style: \_\_\_\_\_ Model: \_\_\_\_\_

**EARMOLDS ARE INCLUDED IN THE PRICE OF THE AIDS**

Left Hearing Aid Charge: \_\_\_\_\_

Right Hearing Aid Charge: \_\_\_\_\_

Option: \_\_\_\_\_ Option: \_\_\_\_\_

Option: \_\_\_\_\_ Option: \_\_\_\_\_

Option: \_\_\_\_\_ Option: \_\_\_\_\_

Option: \_\_\_\_\_ Option: \_\_\_\_\_

**Left HA Charge + Option Charge:** \_\_\_\_\_

**Right HA Charge + Option Charge:** \_\_\_\_\_

Applicable sales tax: \_\_\_\_\_ Date aids dispensed: \_\_\_\_\_ Diagnosis code: \_\_\_\_\_

**DIAGNOSTICS SERVICES** All fees for diagnostic services performed for this patient are paid directly to the clinic. Please refer to the HearPO Testing & Services Price Guide for appropriate charges.

<b>Payment Information</b>	
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Payment must be collected from patient in full at the time of dispensing and should be forwarded to HearPO, along with this form, within 24 hours. *Payment collected for diagnostic services is NOT forwarded to HearPO.* Please enter the appropriate information below. Please fax completed form to 763-496-0259.

- Credit Card** – Amount Due \_\_\_\_\_  
 **Visa**    **Mastercard**    **American Express**  
 **Discover**

- Check** – made payable to HearPO  
 Check Number: \_\_\_\_\_

**Credit Card Number:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

The above information on the purchase of hearing aids has been explained to me and I understand its contents. I understand 100% of the amount due must be received with this order to receive the discounted price. Hearing aids may be returned within 60 calendar days for exchange or refund of all moneys. A refund will be processed immediately upon receipt of the HearPO Return Form which must be completed by your provider, and confirmation from the manufacturer that the hearing aid has been returned. One year of follow up services and adjustments are included in the price of the hearing aid. My signature authorizes HearPO to bill my credit card or confirms that a check is being forwarded to HearPO.

**Audiologist's Signature** \_\_\_\_\_ **Patient's Signature** \_\_\_\_\_



**HearPO  
Prior Authorization Form  
For Washington Self Insured Assoc. Claimants**

**This authorization is valid through xx/xx/xxxx.**

**Patient and Provider Information**

**Patient Information:**

“Patient Name”  
“Patient Address”

**Provider Information:**

“Provider Name”  
“Provider Address”

**Hearing Aids & Diagnostic Services**

**HEARING AID (S) DISPENSED:** Please note that HearPO brand hearing aids must be dispensed for this patient. All hearing aids require specific authorization from employer through HearPO before aids are ordered. For plan details please refer to the Washing Self Insured Assoc. matrix located in exhibits section of your provider manual.

<b>Left</b>	Hearing Aid Code: _____	<b>Right</b>	Hearing Aid Code: _____
	Model: _____		Model: _____
	Style: _____		Style: _____
	Option: _____		Option: _____
	Option: _____		Option: _____
	Option: _____		Option: _____

**Diagnostic Services** If an audiogram was provided with the Independent Medical Evaluation and is less than 6 months old, additional testing will not be authorized. All diagnostic testing must be authorized through HearPO.

Hearing Test 92557 Approved: \_\_\_ Yes \_\_\_ No

**Date Services Performed:** \_\_\_\_\_

**Billing Information**

HearPO private label hearing aids are the covered product for Washington Self Insured Assoc.; therefore providers must be dispensed HearPO brand aids. All hearing aids require specific authorization from the employer through HearPO before the aids are ordered. Please fax this form along with a typed report and any testing performed to (763) 496-0259.

I authorize HearPO to bill my employer for the above services and products.

**Audiologist’s Signature** \_\_\_\_\_ **Patient’s Signature** \_\_\_\_\_

## **5.2 Service Request Form**



FOR OFFICE USE ONLY:

## HEARPO SERVICE REQUEST FORM

PLEASE COMPLETE ALL FIELDS

TODAY'S DATE \_\_\_\_\_ FAX FORM TO: (763) 268-4210

CLAIMANT NAME \_\_\_\_\_ SS#: \_\_\_\_\_

EMPLOYER (even if retired) \_\_\_\_\_ CLAIM #: \_\_\_\_\_

CLAIMANT ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CLAIMANT PHONE (\_\_\_\_) \_\_\_\_\_

HEARPO PRACTICE #: \_\_\_\_\_ PROVIDER: \_\_\_\_\_

FAX: \_\_\_\_\_ PHONE: \_\_\_\_\_

**REPAIR INFORMATION:**

**LEFT**

**RIGHT**

Manufacturer & Model \_\_\_\_\_

Technology Type:      **Basic**      **Programmable**      **Digital**      ← PLEASE CIRCLE

Serial Number: \_\_\_\_\_

Date of fit: \_\_\_\_\_

Service Needed: \_\_\_\_\_

Reason: \_\_\_\_\_

HEARING TEST REQUESTED (check if requesting an audiogram/92557):

REASON FOR REQUEST:

PREVENTATIVE PRETECTION PLAN (provided once per year, only for aids under new program):

REASON FOR REQUEST:

MISCELLANEOUS REQUEST

## 5.3 Hearing Aid Justification

Worker's Compensation laws require employees to be fit with hearing aids that are "medically necessary" so that hearing can be returned to "functional" levels. State laws do not stipulate that employees be fitted with the "best" hearing aids available. To that end, employers have requested that HearPO audiologists review all requests for hearing aids for audiologic appropriateness and necessity.

**HearPO audiologists require certain basic information from providers to authorize Level 2 products. All requests must include: the HearPO prior authorization form, the most recent audiogram (within the last six months) and the Hearing Aid Justification Questionnaire. It is the provider's responsibility to document the justification for their recommendations, and this justification remains part of the employee's patient record.**

The justification report must include the following before prior authorization can be granted:

- New or replacement hearing aid request.
- Brief patient case history, specifically how it relates to the hearing loss and hearing aids; this should include any pertinent information on the patient's previous history with amplification, specifically the make, model, and success or failures with the product(s).

**The HearPO staff audiologist reviews this information to ensure that the recommended hearing aids are appropriate for managing the claimant's audiologic, physical and medical requirements. They also ensure the claimant receives hearing aids that are not less advanced than those he/she previously wore.**

- Background on the patient's current employment status and how their hearing loss affects them in a work environment or with regard to safety issues.

**The HearPO staff audiologist ensures that the recommended hearing aids are compatible with his/her work environments (i.e. wearing of hard hats, head gear or ear protection, telephone usage) and are able to assist him/her in their work communications. They also specifically take into account work situations where the safety of the claimant and/or others is contingent on the claimant's ability to hear and communicate with minimal distractions.**

- Explanation of slope and degree of hearing loss and how that impacts your recommendations for amplification. Is recruitment present? Explanation of speech discrimination abilities (quiet and in noise) and how they impact your recommendations for amplification.
- Are the patient's wants, desires, or expectations impacting your recommendations in any way? If so, how? Please document if you are recommending something specifically due to these types of patient factors. Always note what your professional recommendation is, if that differs from what the patient is asking you to request.

**HearPO requires this documentation so we have information relating to the claimant's personal desires. This is especially important when cosmetic issues negatively impact audiologic appropriateness or when the claimant and the provider differ in terms of the request.**



- Are there any other extenuating issues (dexterity problems, ear size, fit issues, allergic reactions, cognitive issues, etc.) that you think should be considered in the review process? If so, please briefly explain how these impact your recommendation.

**HearPO takes these issues into account when deciding if additional features or more advanced technology is warranted to manage specific problems.**

- Please note the exact style, make, and model of aids you are requesting.

Please do not hesitate to contact the HearPO Director of Professional Services with any questions or for further clarification. Just like you, we'd like this to be done correctly the first time!



# 5.4 Hearing Aid Justification Questionnaire

This form is only required when a hearing aid is recommended beyond Level 1 and for replacement hearing aid(s).

Claimant Name:  
Address:  
Phone #:  
SSN:  
Claim #:  
Employer:

Provider Name:  
Provider Title:  
Phone #:  
Fax #:  
Site # (required):

***Please submit audiogram with hearing aid request.***

**New Hearing Aid Request**

**Replacement Hearing Aid Request**

Is claimant still employed with employer claim is through?  Yes  No

If yes, what are job duties or special circumstances that need to be considered:

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### **Audiologic Findings:**

Please attach copy of audiogram.

**Please note, speech-in-noise testing and LDL's must be conducted to consider ANY Level 2 hearing aid.**

**Physical limitations that need to be considered (i.e. no pinna, dexterity, etc).**

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**Has the claimant expressed size preference to you?**  Yes  No

**Do you feel this meets Audiologic appropriateness?**  Yes  No

(All hearing aid recommendations must have thresholds within the best fit criteria of the manufactures fitting guide. This is verified by HearPO before request is submitted to the employer.)

**For Replacement Request, please provide information on current hearing aid.**

Type: Conventional          Programmable          Digital

Manufacturer and Model: \_\_\_\_\_

Serial Number: \_\_\_\_\_

Size:    BTE          ITE          HS          ITC          Mini ITC          CIC

Are current hearing aids malfunctioning?       Yes       No

If yes, please explain:

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Have current hearing aids had excessive repair history?       Yes       No

If yes, please provide a repair history, including what was repaired and reason for repair. Manufacturers repair invoices would suffice.

Have you contacted manufacturer to determine if hearing aid can be repaired?

Yes       No

If yes, please provide manufacturers explanation:

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Based off of the need for medical necessity, justification provided, and previous hearing aid experience, please select the hearing aid you feel is " medically necessary" for this claimant. If a Level 2 product is selected, a secondary recommendation from Level 1 also needs to be included and will be returned if not provided. If requirements and justification are met to provide a Level 2 product, recommendation will be sent to the employer for approval or denial.

Option One: \_\_\_\_\_

HearPO code: \_\_\_\_\_

Options: \_\_\_\_\_

Option Two: \_\_\_\_\_

HearPO code: \_\_\_\_\_

Options: \_\_\_\_\_

Please include any options to the hearing aid that you feel are necessary. If the options are not requested, they cannot be approved.



**PREVENTATIVE PROTECTION PLAN REQUEST FORM**

Please fax form for reimbursement to be approved and collected. Please note: Reimbursement is only provided once hearing aid(s) is one year old and on an annual basis, based on date of service.

TODAY'S DATE \_\_\_\_\_ FAX FORM TO: (763) 268-4210 or (763) 496-0259

CLAIMANT NAME \_\_\_\_\_ SS#: \_\_\_\_\_

EMPLOYER (even if retired) \_\_\_\_\_ CLAIM #: \_\_\_\_\_

CLAIMANT ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CLAIMANTS PHONE NUMBER: \_\_\_\_\_

HEARPO PRACTICE #: \_\_\_\_\_ PROVIDER: \_\_\_\_\_

FAX: \_\_\_\_\_ PHONE: \_\_\_\_\_

***Services required with initial approval of PPP:***

- Clean and check  Hearing Screening  Electroacoustic Evaluation/programming

***Additional services included for the year:***

- Replace tubing/earhooks/wax filters  Impressions for remakes/earmolds
- Hearing aid sent to manufacturer for in warranty repair (Out of warranty repairs require approval)
- Product(s), less than \$15 acquisition cost and a combined invoice total of \$25 included for the year : \_\_\_\_\_
- Other: \_\_\_\_\_

**\*\*The PPP is an annual service agreement from date services performed.\*\***

**Date Services Performed or To Be Performed:** \_\_\_\_\_

**Providers Signature:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient signature required once services performed.

For Office Use:



## HearPO Universal Plan Request for Authorization

**Provider Information (include name, address, phone and fax numbers):**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**Patient Information:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**Services Requested (type of service by CPT or V code, please be specific):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hearing Aids Requested:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Fax to HearPO at: 763-268-4210**

## **5.5 Final Authorization Form**

HearPO
Final Hearing Aid Authorization Form
For WASHINGTON SELF INSURED ASSOC.
Claimants

650649

Patient Information

Provider Information

"Patient Name"
"Patient Address"

"Provider"
"Provider Address"

Hearing Aids & Diagnostic Services

Hearing Aids(s) Dispensed Only authorized devices and options can be ordered by and paid to provider. Please do not add any additional circuitry without authorization.

Left Hearing Aid Code: Right
Model: Model:
Style: Style:
Option: Option:

DIAGNOSTIC SERVICES & MISC. SUPPLIES: The following diagnostic services and/or supplies have been authorized for this patient.

Description Code Price

\*\*Batteries are being mailed directly to the claimant at the address listed above. Please verify mailing address is correct. If claimant will not be fit with the approved hearing aid(s) with 4 weeks, please notify HearPO.

Date Services Performed: Battery size:

Payment Information

Please note that HearPO brand hearing aids must be dispensed for this patient. Receipt of this form authorizes you to order the hearing aids from the manufacturer, using HearPO's Bill-to account number and the provider's ship-to account number. Please enter all requested information and fax to HearPO at (763) 496-0259 within 24 hours of dispensing the hearing aids.

Patient and Provider: By signing this authorization, I am confirming that all of the above services and products were delivered on the dates indicated above.

Left Serial Number: Right Serial Number:

Date Hearing Aids Dispensed: Warranty Expiration Date:

Audiologist's Signature Patient's Signature



# 5.6 Patient Grievance Form

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Grievance: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_

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### For Office Use Only

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Date In: \_\_\_\_\_ Date Out: \_\_\_\_\_

Ruling: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**QAC Member Signature:** \_\_\_\_\_



# 5.7 Provider Grievance Form

Date: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Patient Name (if pertinent): \_\_\_\_\_

Date of Service (if pertinent): \_\_\_\_\_

Grievance: \_\_\_\_\_

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Provider Signature: \_\_\_\_\_

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### For Office Use Only

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Date In: \_\_\_\_\_ Date Out: \_\_\_\_\_

Ruling: \_\_\_\_\_

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QAC Member Signature: \_\_\_\_\_

## **5.8 Patient Satisfaction Survey**



## HEARING AID SATISFACTION SURVEY

- Overall, how **satisfied** are you with your most recently purchased hearing aid(s)?  
(√ **one**)
 

5 <input type="checkbox"/> Very Satisfied	2 <input type="checkbox"/> Dissatisfied
4 <input type="checkbox"/> Satisfied	1 <input type="checkbox"/> Very Dissatisfied
3 <input type="checkbox"/> Neutral (neither satisfied nor dissatisfied)	
- Would you **recommend the person/office**, who fit your most current hearing aid(s), to a friend or relative with a hearing problem?
 

1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	3 <input type="checkbox"/> Not sure
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- When it is time to replace your hearing aid, would you **repurchase** your **current brand** of hearing aid? (√ **one**)
 

1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	3 <input type="checkbox"/> Not sure
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- When you phoned 1-888-HEARING to initiate the Prior-Authorization Process, did a HearPO representative answer your phone call or did you leave a message?
 

1 <input type="checkbox"/> Answered by a HearPO Associate	2 <input type="checkbox"/> Left a message
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- Listed below are service factors that relate to the HearPO associate that you spoke with. For each service factor please check one box to show **how satisfied** you are with the **service factors** (√ **one box for each service factor**).

<u>Service Factor</u>	<u>Very Satisfied</u>	<u>Satisfied</u>	<u>Neutral</u>	<u>Dissatisfied</u>	<u>Very</u>
Professionalism of associate	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Friendliness of associate	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Associate's knowledge of the process	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Patience of associate	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Explanation of the entire process	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

- Overall, how satisfied are you with the level of service HearPO provided?  
(√ **one**)
 

5 <input type="checkbox"/> Very Satisfied	2 <input type="checkbox"/> Dissatisfied
4 <input type="checkbox"/> Satisfied	1 <input type="checkbox"/> Very Dissatisfied
3 <input type="checkbox"/> Neutral (neither satisfied nor dissatisfied)	
- Overall, how satisfied are you with the overall process of obtaining your hearing aids?  
(√ **one**)
 

5 <input type="checkbox"/> Very Satisfied	2 <input type="checkbox"/> Dissatisfied
4 <input type="checkbox"/> Satisfied	1 <input type="checkbox"/> Very Dissatisfied
3 <input type="checkbox"/> Neutral (neither satisfied nor dissatisfied)	



8. Listed below are some hearing aid features. For each feature, please check one box to show **how satisfied** you are with that feature. The term Neutral means neither satisfied nor dissatisfied (✓ one box for each feature).

<u>Hearing aid feature</u>	Very				Very
	Satisfied	Satisfied	Neutral	Dissatisfied	
Overall fit/comfort	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Hearing aid size	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Ease of changing battery	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Battery life	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Clearness of tone and sound	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Whistling/feedback/buzzing	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Ease of adjusting volume	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Reliability	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Appearance of the hearing aid	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Improves your hearing	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Use in noisy situations	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
On-going expense of hearing aid	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Value	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Warranty on the hearing aid(s)	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Packaging of the hearing aid(s)	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Discount you received	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

9. Listed below are some features about the **service from the person who fit your hearing aid(s)**. For each service factor please check one box to show **how satisfied** you are with the **service factors** (✓ one box for each service factor).

<u>Service Factor</u>	Very				Very
	Satisfied	Satisfied	Neutral	Dissatisfied	
Professionalism of audiologist	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Audiologist's knowledge of hearing aids	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Patience of audiologist	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Explanation of hearing test	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Explanation on how to use and care for your hearing aids	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Explanation of what to expect from your hearing aids	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Amount of time audiologist spent with you	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Cleanliness/appearance of audiologist's office	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Quality of service <b>after</b> purchase	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Friendliness of audiologist's receptionist	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>
Promptness of service	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>

## **5.9 Provider Credentialing Forms**



Provider: \_\_\_\_\_  
Practice(s): \_\_\_\_\_  
Date: \_\_\_\_\_

## Credentialing Checklist

**HearPO requires current copies of the following items in order to complete the credentialing process. Please complete and forward all requested materials within 10 days. Each provider, to be credentialed at your facility, fills out the HearPO Application, Provider Credentialing Interview and Provider Agreement.**

- HearPO Application
- Completed Provider Credentialing Interview
- Completed Provider Agreement
- \*Practice Credentialing Interview
- \*W-9 Form

\*These forms do not need to be filled out if you are adding a provider to an already credentialed site.

**COPIES of the following items must be attached:**

- State Audiology License (*showing expiration*)
- State Hearing Aid Dispensing License (*showing expiration*)
- Liability Insurance Certificate (*required 1 million per occurrence/3 million aggregate*)
- Master's or Doctorate Degree

**Please forward this checklist and all requested materials to:**

**HearPO Credentialing  
5000 Cheshire Lane North  
Plymouth, MN 55446  
763-496-0259-fax**



## Membership Application

(Please fill out form completely)

Providers Name: \_\_\_\_\_

Please Select:     AUDIOLOGIST                       HEARING INSTRUMENT SPECIALIST

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_ County: \_\_\_\_\_

### CREDENTIALS

Highest Degree (please circle one): BA/BS      MS/MA PhD      AUD      Other: \_\_\_\_\_

Institution & Location: \_\_\_\_\_

AUDIOLOGY LICENSURE    State: \_\_\_\_\_    Licensure #: \_\_\_\_\_    Exp. Date: \_\_\_\_\_

HEARING AID LICENSURE    State: \_\_\_\_\_    Licensure #: \_\_\_\_\_    Exp. Date: \_\_\_\_\_

NPI #: \_\_\_\_\_

Business License #: \_\_\_\_\_    State: \_\_\_\_\_

### PRACTICE PROFILE

Number of years practicing audiology: \_\_\_\_\_    Numbers of years dispensing: \_\_\_\_\_

Corporate affiliations or franchise relationship: \_\_\_\_\_

Total number of sites within practice: \_\_\_\_\_    Total number of sites you visit: \_\_\_\_\_

What hearing aid manufacturers do you primarily dispense: \_\_\_\_\_

How would you classify your dispensing site (please circle one):

- |                             |                           |
|-----------------------------|---------------------------|
| 1) Hearing Aid Office/Store | 4) Hospital               |
| 2) Family Doctor's Office   | 5) ENT Office             |
| 3) Audiology Practice       | 6) Clinic of HMO          |
|                             | 7) Other (specify): _____ |

**I hereby authorize HearPO to review all credentials with the appropriate governing board. I also understand that submission of this application does not guarantee provider status, nor does it constitute HearPO acceptance of such status.**

Applicant's signature: \_\_\_\_\_    Date: \_\_\_\_\_

**HearPO Credentialing**  
5000 Cheshire Lane North  
Plymouth, MN 55446  
Fax: 763-496-0259



## Provider Credentialing Interview

This form must be completed for each Provider in your practice.

Applicant Name: \_\_\_\_\_

Names(s) of Current Practice(s): \_\_\_\_\_

E-mail Address: \_\_\_\_\_

<b>Confidential Professional Information - Required by NCQA Standard CR 4</b>	
Has your license to practice in any jurisdiction ever been denied, restricted, limited suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?	Y/N
Have you ever been reprimanded, disciplined, counseled or been subject of similar action by any state-licensing agency with respect to your license to practice?	Y/N
Have you ever been denied participation in Medicaid or any other governmental or quasi-governmental health-related program?	Y/N
Are you currently using illegal drugs?	Y/N
Have you ever been convicted of a felony?	Y/N
Have you ever been refused participation in the network of a managed care organization (HMO or PPO) or been disciplined by or terminated from such a plan or organization?	Y/N
Are you privacy HIPAA compliant ?	Y/N
Are you electronically HIPAA compliant? (Not applicable if your clinic does not electronically transmit any data/billing to any payor/clearing house.)	Y/N/NA

Work History - NCQA CR 3.6 requires, at a minimum, five years of work history. Please list the employer name, and period of employment for positions you have held for the past five years. If you do not have five years experience, please list employment for the time period that you have worked. A current curriculum vita is also acceptable and may be attached.

**Employer**

**Dates of Employment**

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_



Please initial each box to acknowledge your review, understanding, and agreement.

Initials	Provider Guideline Review
	<p>B. HearPO grants provider status to an individual provider within an approved practice. If a provider leaves the approved practice, they will need to reapply to become an approved provider at the new practice.</p>
	<p>C. All advertising including, but not limited to, recall letters, promotions and yellow pages ads which solicits patients from HearPO accounts or uses the HearPO name must be submitted to HearPO for review and approval.</p>
	<p>D. HearPO has a No Cause Termination Clause.</p>
	<p>E. HearPO centralizes communication between providers, insurance groups, employers and third- party administrators. Providers are not to contact these groups directly. All questions, comments, or concerns are to come through HearPO.</p>
	<p>F. All claims are submitted to HearPO directly for processing and reimbursement. Claims are not to be submitted directly to payers.</p>
	<p>G. In the event of direct claims payment from a payer to a provider, the provider must report this payment to HearPO.</p>
	<p>H. When an administrative fee cannot be included in the cost paid by the third-party payer, there is a minimum 12% administrative fee withheld by HearPO from claims paid.</p>
	<p>I. Proper authorization must be obtained prior to providing services or devices that require pre- authorization (per contract) by submitting either a justification letter or a HearPO Service Request Form (whichever is appropriate) directly to HearPO. Claims received for services or devices requiring pre-authorization that have not been properly authorized may not be paid.</p>
	<p>J. All claims are to be submitted within 30 days from the date of service.</p>
	<p>K. All claims must be submitted on the HearPO Prior Authorization Forms or CMS 1500 form for reimbursement.</p>
	<p>L. CMS 1500 forms are to be used and completed as per contract requirements. Some payers require that a provider's usual and customary pricing be listed on the HCFA, while others require the cost as listed on the encounter form for that plan.</p>
	<p>M. Incomplete or incorrect claims and/or vouchers will be returned to the provider with an explanation. Claims will be submitted to the payer for reimbursement by HearPO upon receipt of accurately completed and valid CMS 1500 or other acceptable form.</p>



	N. The Health Care Procedure Coding System (HCPCS) V- Codes are to be used for hearing aids and hearing aid related services. Physician's Current Procedure Terminology (CPT) codes are to be used for diagnostics.
	O. Providers are updated on contract specific guidelines and updates via newsletters, broadcast fax, e-mail, or mailing.
	P. Verification of ten (10) hours/1 Continuing Education Unit (CEU) available for HearPO to view when requested.
	Q. Providers must notify HearPO of lawsuits or judgments against the provider or practice.
	R. HearPO Providers cannot process claims for non-HearPO providers.
	S. Upon renewal of professional liability insurance or hearing aid dispensing licensure, a current copy must be faxed or mailed to HearPO immediately.
	T. Changes in provider staff or location are to be reported to HearPO immediately.

**I hereby authorize HearPO to review all credentials with the appropriate governing board. I also understand that submission of this credentialing interview does not guarantee provider status, nor does it constitute HearPO's acceptance of such status.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please forward completed Interview to:**

**HearPO Credentialing  
5000 Cheshire Lane North  
Plymouth, MN 55446  
763-496-0259-fax**



## **HEARPO PROVIDER AGREEMENT**

This Provider Agreement ("Agreement") is entered into this \_\_\_\_\_ day of \_\_\_\_\_, 200\_, by and between \_\_\_\_\_ ("Provider") and HearPO Corp. ("HearPO") (Provider and HearPO collectively, the "Parties").

WHEREAS, HearPO has contracts with various entities and persons, including, but not limited to, insurance carriers, self-insured employers, member health programs, unions, associations, and workers compensation programs (collectively referred to as "Payors") to develop and maintain a network of providers of audiology services and hearing aid products ("Audiology Services"), and to have those providers furnish Audiology Services to members (collectively referred to as "Members") of health benefit plans offered by Payors ("Plans"), some of which Plans are regulated by the Medicare program,

NOW, THEREFORE, the Parties agree as follows:

### **SECTION 1 – SERVICES TO MEMBERS**

1.1 PATIENT CARE. Provider shall provide Audiology Services to Members in a culturally competent manner that is consistent with professionally recognized standards of care. Provider shall not discriminate in the access to, treatment of, or quality of service rendered to Members on the basis of age, sex, marital status, sexual orientation, ethnicity, national origin, religion, health status, disability (mental or physical), or payment source.

1.2 PROVIDER REQUIREMENTS. Provider shall perform services in the manner and in accordance with the procedures specified in the HearPO Resource Manual, as amended from time to time and supplied to Provider by HearPO. Provider shall comply with all other policies and procedures specified in writing from time to time by HearPO.

1.3 PATIENT RECORDS. Provider shall maintain in a timely manner detailed and accurate records of all services performed for, and all products sold or supplied to, Members of the Plans. Provider shall ensure the confidentiality of such records and shall release such information only in accordance with state and federal law.

1.4 ELIGIBILITY. Provider is responsible for determining whether HearPO has an active contractual relationship with the patient's Payor and that the patient is an eligible Member of a Plan prior to performing Audiology Services. HearPO has no responsibility for eligibility determinations for any Plan. However, upon request by a Provider, HearPO will use reasonable efforts to contact any involved Plan on behalf of Provider to resolve eligibility questions.

1.5 ACCESSIBILITY. Provider shall meet or exceed any accessibility standards applicable to Provider that are set forth in the HearPO Resource Manual or are established by state or federal law.

1.6 CONTINUATION OF CARE. In the event of non-payment by HearPO to Provider for Audiology Services, Provider shall nevertheless continue to provide Audiology Services to Members covered by a Plan ("Covered Services") for the duration of the period for which payments have been made to the Payor under any prepaid Plan.

### **SECTION 2 – CLAIMS AND PAYMENTS**



2.1 CLAIMS. Provider is responsible for initiating the payment process by completing and submitting to HearPO, as more fully described in the HearPO Resource Manual, a benefit voucher and a uniform claim form (*i.e.*, HCFA form 1500). Original forms shall be sent to the HearPO address specified in Section 8.7 below, or such other address as HearPO may designate in writing.

2.2 PAYMENT. Provider shall be compensated for Audiology Services provided to eligible Members solely and exclusively according to the terms of the applicable Plan, as described in the HearPO Resource Manual. Provider may bill or charge Members only for (1) co-payments or deductibles specified in the Members' Plan, (2) cost-sharing and balance billing amounts specified in indemnity portions of any Plan, (3) Audiology Services that are not covered by the Members' Plan ("Noncovered Services"), or (4) where expressly permitted by HearPO and the Plan, amounts in excess of allowable amounts. Prior to rendering Noncovered Services, Provider shall obtain a written agreement from the Member that the Member will be solely liable for payment of the Noncovered Services. Provider acknowledges that under certain Plans, HearPO may deduct from amounts due to Provider an amount equal to a certain percentage (the "Withhold Percentage") of the total value of the Audiology Services provided to an eligible Member. The Withhold Percentage is currently 12 percent, but may be increased by HearPO in its sole discretion by not more than two percent in any twelve-month period upon 30 days' prior notice to Provider; provided, however, that the Withhold Percentage will not exceed 15 percent at any time.

Provider shall accept as full payment under any Plan (1) those amounts paid for Covered Services by the Members' Plan through HearPO, as specified in the fee schedule set forth in the HearPO Resource Manual ("Fee Schedule"), plus (2) amounts for which the Member is responsible, as identified in this Section 2.2. Except as provided herein, Provider agrees that in no event, including, but not limited to, nonpayment by HearPO, HearPO's or the Payor's insolvency, or HearPO's breach of this Agreement, shall Provider bill, charge, collect a deposit, seek compensation, remuneration or reimbursement from, or maintain any action at law or pursue any other recourse against, or make any surcharge upon, a Member or other person acting on a Member's behalf (other than HearPO) for any amounts that the Payor or HearPO is responsible to pay under a prepaid Plan, such as a Medicare + Choice or health maintenance organization plan.

If HearPO receives notice of any collection by Provider of funds in excess of allowable amounts, it may take appropriate action, including, but not limited to, terminating this Agreement for cause and requiring the immediate refund of any amounts collected from the Member.

Provider agrees that this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Members and that this provision supersedes any oral or written agreements to the contrary now existing or hereafter entered into between Provider and a Member or person acting on behalf of a Member. Any modification, addition, or deletion to the provisions of this hold harmless clause shall become effective on a date no earlier than 15 days after (1) the applicable state regulatory agency has received written notice of such proposed changes and (2) HCFA has approved in writing such proposed change (in the case of any Medicare + Choice Plan).

2.3 COORDINATION OF BENEFITS. On an on-going basis, Provider must notify HearPO when Provider learns that a Member has benefit coverage other than the Plan.

2.4 HEARING AID RETURNS. Provider shall permit any eligible Member to return any hearing aid product at any time for any reason within 60 days of purchase. Upon such return, Provider shall notify HearPO in writing, and shall either not charge the Member and the involved Payor, or shall refund to HearPO and the Member all amounts received for the returned hearing aids.

### **SECTION 3 – HEARPO RESPONSIBILITIES**



3.1 CLAIMS. HearPO shall receive and process or forward to the Payors each completed claim form submitted by Provider pursuant to the requirements specified in this Agreement and the HearPO Resource Manual.

3.2 PAYMENT TO PROVIDER. In accordance with the terms specified in the HearPO Resource Manual, HearPO shall pay Provider all amounts due to Provider, as specified in the Fee Schedule. HearPO shall ensure that claims for which it is financially responsible relating to services furnished by Provider under a Medicare + Choice Plan are processed (i.e., paid or denied) as follows: (i) all claims (clean or deficient) submitted by Providers are processed within no more than 60 days, or (ii) upon any other terms and within such timeframes as required by HCFA.

3.3 LIST OF PROVIDERS. HearPO shall provide to the Payors with the frequency specified by the Payors lists of providers, including Provider, qualified to provide Audiology Services to Plan Members.

3.4 RESOURCE MANUAL. HearPO shall supply Provider with an up-to-date HearPO Resource Manual, and shall supply supplementary information and requirements from time to time, in writing.

3.5 COMMUNICATIONS WITH PAYORS. HearPO shall assist Provider in resolving payment and eligibility issues with Plans by communicating to the Payors such information, requests, and questions as reasonably submitted by Provider, and by communicating to Provider responses from the Payors.

#### **SECTION 4 – PROVIDER RESPONSIBILITIES**

4.1 HEARPO RESOURCE MANUAL. Provider shall comply with all accessibility standards, medical policies, claims submission and payment, quality management, and utilization management programs in accordance with the requirements established in the then current HearPO Resource Manual.

4.2 INSURANCE. Provider shall carry and retain malpractice and liability insurance in the amount of at least \$1 million per occurrence/\$3 million in the aggregate, and shall supply to HearPO evidence of such coverage annually.

4.3 CREDENTIALS. Provider has and will maintain at all times, and will employ or otherwise utilize audiologists who have and will maintain at all times, all licenses, certifications, and credentials specified under federal, state, and local law, including, without limitation, all laws and regulations governing reimbursement under the Medicare program. Each audiologist affiliated with Provider shall earn at least 10 continuing education credits per year. Provider shall provide to HearPO annual evidence of the licenses, certifications, and continuing education units required in this section.

4.4 ACCESS TO RECORDS. Provider shall retain and permit HearPO, any state or federal agency, including, but not limited to, the United States Department of Health and Human Services, the Comptroller General of the United States, the Health Care Financing Administration ("HCFA"), or their designees, to audit, evaluate, and inspect all medical, billing, evaluation, utilization, and other records of Provider, to the extent that such records relate to any aspect of the Audiology Services performed for Members. This right to inspect and audit shall extend no less than 6 years from the later of (1) the last day of the calendar year in which the books or records were created, (2) the date of completion of any audit relating to those books and records by the Department of Health and Human Services, the Comptroller General, HCFA or their designees, or (3) such other date determined by HCFA in accordance with its regulatory authority. To the extent requested by state or federal officials under their regulatory authority, Provider shall furnish copies of such books and records to HearPO at no charge. Provider shall provide



access to and make available its premises, physical facilities and equipment to state and federal authorities for audit and compliance review purposes.

4.5 NO CONTRACTS. During the term of the Agreement and for a period of one year after the termination of this Agreement, Provider shall not solicit or contract with any Payor with which HearPO contracts as of the date of such termination, or in any way cause any such Payor to alter, modify, or terminate its relationship with HearPO.

4.6 COMMUNICATIONS WITH MEMBERS. All letters used by Provider with respect to claim determinations for Members shall conform to HCFA requirements and guidelines.

4.7 CERTIFICATION OF ENCOUNTER DATA. Where applicable, Provider shall certify to its best knowledge, information, and belief, as to the accuracy, completeness and truthfulness of encounter data pertaining to Audiology Services provided to Members.

4.8 QUALITY IMPROVEMENT REVIEW. Provider shall participate in and fully cooperate with any quality improvement review implemented by HearPO, any Payor, or any independent quality review and improvement organization with which a Payor contracts.

4.9 MEMBER COMPLAINTS AND DISPUTES. All complaints concerning Provider shall be addressed in accordance with the procedures specified in the HearPO Resource Manual. If HearPO determines that it is appropriate to suspend or terminate the Provider's right to provide Audiology Services under this Agreement, it shall provide written notice to the Provider detailing the grounds for the suspension or termination and the procedure and time limits for Provider to appeal HearPO's decision.

4.10 COMPLIANCE WITH LAWS AND RULES. Provider acknowledges that certain Payors are obligated under certain Plans to oversee and be accountable to HCFA for the services provided and activities performed by Provider pursuant this Agreement. Provider agrees to comply with (1) Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84, (2) the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, (3) the Rehabilitation Act of 1973, (4) the Americans With Disabilities Act, (5) all laws applicable to recipients of federal funds, and (6) all other state and federal laws and rules applicable to the Audiology Services provided under this Agreement. Provider will cooperate and participate in HearPO's efforts to comply with applicable statutory and regulatory requirements to the extent reasonably requested by HearPO. With respect to any Medicare + Choice Plan, Provider shall provide all Audiology Services to Members and perform all other activities required by this Agreement consistent with and in compliance with contractual obligations of Payors to HCFA.

## **SECTION 5 -- SUBCONTRACTS**

In order to verify compliance with federal or state requirements, HearPO shall have the right to access, review, and approve any contracts between Provider and any other entity or independent contractor through which Provider performs Audiology Services under this Agreement ("Subcontractors"), and to receive copies of such documents at no additional charge to HearPO. Provider shall transmit the requested information or documents to HearPO regarding subcontracted arrangements within one business day of a written request, and HearPO may disclose or report the information or documents as required by applicable laws or regulations. Provider will ensure that such contracts with Subcontractors shall contain provisions that meet the requirements set forth in Exhibit A, attached hereto and incorporated herein, to the extent the Subcontractor provides services under a Medicare + Choice Plan.

## **SECTION 6 – TERM AND TERMINATION**



6.1 TERM. This Agreement shall become effective as of the date stated at the beginning of this Agreement, and shall remain in effect for a one-year term, which shall be renewed automatically on a year-to-year basis, unless terminated sooner.

6.2 TERMINATION PRIOR TO RENEWAL. Either party may terminate this Agreement, without cause, by giving the other party 90 days' prior written notice of such termination.

6.3 TERMINATION FOR BREACH. Either party shall have the right to terminate this Agreement on 30 days' prior written notice if the party to whom such notice is given breaches any material provision of this Agreement. The party claiming the right to terminate must set forth in the notice the facts underlying its claim that the other party is in breach. If HearPO seeks to terminate this Agreement, it must also set forth in the notice details of the process for the Provider to appeal HearPO's decision to terminate the Agreement.

6.4 SURVIVAL. The provisions of Sections 1.3, 2.2, 2.5, 4.4, 4.5, and 7 shall survive the termination of this Agreement and shall remain in force and effect for 10 years thereafter.

## **SECTION 7 – LIABILITIES AND DISPUTES**

7.1 INDEMNITY. HearPO shall not be liable for any claims, injuries, demands, or judgments based upon negligence, warranty or any other grounds arising out of the manufacture, dispensing, sale, or provision of any goods or services by Provider to any Member and Provider agrees to indemnify and hold HearPO and its affiliates harmless from any and all such claims, liabilities, damages, and losses, including reasonable attorneys' fees at trial or on appeal in the event of such action.

7.2 WAIVER OF BREACH. Waiver by any party of any breach of any provision of this Agreement or the failure to insist upon strict compliance with any provision of this Agreement shall not operate or be construed as a waiver of such provision or any other provisions.

7.3 DISPUTE RESOLUTION. Any dispute arising under or related to this Agreement shall be resolved before a single arbitrator acting under the rules of the American Arbitration Association. Any dispute shall be resolved with a written opinion, rendered by the arbitrator not later than 120 days after the appointment of the arbitrator. The Parties agree that this 120-day period may be tolled for up to 60 days to permit mediation of any dispute. The arbitrator shall be authorized to tax costs and attorneys' fees against the losing party. The arbitration proceeding shall take place in Plymouth, Minnesota.

## **SECTION 8 – MISCELLANEOUS**

8.1 INDEPENDENT CONTRACTORS. None of the provisions of this Agreement are intended to create between Provider and HearPO any partnership, joint venture, agency, employment, representative or any other relationship other than that of independent contractors.

8.2 FORCE MAJEURE. Neither party shall be liable or deemed in default of this Agreement for any delay nor failure to perform caused by Acts of God, war, disasters, strikes, or any similar cause beyond the control of either party.

8.3 ADVERTISING MATERIAL. Provider shall conduct all advertising and promotion of services in a manner consistent with the Provider Requirements set forth in the HearPO Resource Manual. Nothing in this Agreement is intended to authorize or license Provider to use any trademarks, symbols, trade names, service marks, or other intellectual property.



8.4 DESCRIPTIVE HEADINGS. The headings of the paragraphs of this Agreement are inserted for convenience and shall not limit, extend, or delineate the scope or intent of the provisions hereof.

8.5 ENTIRE AGREEMENT. This Agreement constitutes this entire Agreement between HearPO and the Provider and shall not be altered or amended except as agreed in a writing signed by the Parties.

8.6 APPLICABLE LAW. It is the intent of the Parties to this Agreement that it shall be subject to and interpreted in accordance with the laws of the State of Minnesota, without regard to principles of conflicts of laws.

8.7 NOTICE. Except as otherwise provided herein, any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be deemed received when sent by certified or registered mail, return receipt requested, to the Parties at the addresses set forth below. Each Party may designate in writing a new address to which any notice required by this Agreement may thereafter be sent. Notices may be sent to HearPO at 5000 Cheshire Lane N., Plymouth, MN 55446. Notices may be sent to Provider at the address specified below.

8.8 SEVERABILITY. In the event any part or parts of this Agreement are held to be unenforceable, the remainder of this Agreement shall continue in effect. 8.9 THIRD-PARTY RIGHTS. The Parties have not created and do not intend to create by this Agreement any enforceable rights in any third party under this Agreement, including, without limitation, Members. The Parties acknowledge and agree that there are no third-party beneficiaries to this Agreement.

**Legal Name of Provider:**

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_



### EXHIBIT A

Provider shall ensure that contracts with Subcontractors providing services under this Agreement contain the following provisions:

- a. Each Subcontractor shall agree that state and federal authorities, including without limitation the United States Department of Health and Human Services, the Comptroller General of the United States, HCFA, or their designees, shall have the right to audit, evaluate, and inspect, any pertinent contracts, books, documents, papers, and records of Subcontractor involving transactions related to this Agreement and such right to audit, evaluate, and inspect shall extend no less than 6 years from the last day of any calendar year in which the books or records were created or from the date of completion of any audit, whichever is later.
- b. Each Subcontractor shall agree to accurately maintain and safeguard the confidentiality of medical records or other health and enrollment information pertaining to Members and release such information only in accordance with state and federal law.
- c. Each Subcontractor shall agree not to discriminate against any Members on the basis of age, sex, marital status, sexual orientation, ethnicity, national origin, religion, health status, disability (mental or physical), or payment source.
- d. Each Subcontractor shall agree to perform all Audiology Services in a culturally competent manner and in accordance with the procedures specified in HearPO's Resource Manual, as amended from time to time. Subcontractor shall agree to comply with all applicable provisions of this Agreement and all other policies and procedures specified in writing from time to time by HearPO.
- e. Each Subcontractor shall agree to the payment provisions set forth in Section 2 of this Agreement.
- f. Each Subcontractor shall agree to perform any activities or functions delegated to it by Provider in accordance with the requirements set forth in this Agreement and the HearPO Resource Manual.
- g. Each Subcontractor shall agree to submit encounter data and, when required by state or federal officials under their regulatory authority, shall certify the accuracy, completeness, and truthfulness of such encounter data to the best of its knowledge, information, and belief. Each Subcontractor shall further agree to submit medical records for the validation of encounter data, when required by HCFA.
- h. Each Subcontractor shall agree to participate in and cooperate with any quality improvement review initiated by HearPO, any Payor, or any quality review and improvement organization with which a Payor contracts.
- i. Provider and its Subcontractors shall agree that their respective contract may not be terminated without cause unless at least 60 days' prior written notice is given to the other.
- j. Each Subcontractor must agree that the subcontract shall be updated and amended as necessary to comply with state and federal laws and rules applicable to the Audiology Services provided under this Agreement.

Subcontracts shall be signed and dated by Provider and its Subcontractor.



## Practice Credentialing Interview

**This document should be completed once for each practice. In it is not necessary to complete this document for each provider. A current copy of your state business license should be forwarded with this document.**

Practice Name: \_\_\_\_\_

Names of all Audiologists at this practice: \_\_\_\_\_

\_\_\_\_\_

Names of all Hearing Aid Dealers (do not include audiologists): \_\_\_\_\_

\_\_\_\_\_

Languages Spoken: \_\_\_\_\_

Corporate/Franchise Affiliation: \_\_\_\_\_

**Primary Location** (All correspondence and reimbursement will be sent to this location unless specified):

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ County: \_\_\_\_\_

Days and hours of operation: \_\_\_\_\_

Names of Audiologists that will be seeing patients at this site: \_\_\_\_\_

\_\_\_\_\_

Please circle the populations this site services:      Pediatric      Adult      Geriatric

Is the practice ADA accessible? Y / N      Is an infection control plan in place? Y / N

Please circle the services performed at this location:

Basic Diagnostic Testing

Hearing Aid Dispensing



**Additional Location:**

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ County: \_\_\_\_\_

Days and hours of operation: \_\_\_\_\_

Names of Audiologists that will be seeing patients at this site: \_\_\_\_\_  
\_\_\_\_\_

Please circle the populations your site services:      Pediatric      Adult      Geriatric

Is this site ADA accessible? Y / N      Is an infection control plan in place? Y / N

Should reimbursements for this site be forwarded to your primary location? Y / N

Should correspondence be sent to this site in addition to your primary location? Y / N

**Additional Location:**

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ County: \_\_\_\_\_

Days and hours of operation: \_\_\_\_\_

Names of Audiologists that will be seeing patients at this site: \_\_\_\_\_  
\_\_\_\_\_

Please circle the populations your site services:      Pediatric      Adult      Geriatric

Is this site ADA accessible? Y / N      Is an infection control plan in place? Y / N

Should reimbursements for this site be forwarded to your primary location? Y / N

Should correspondence be sent to this site in addition to your primary location? Y / N

Interview Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Please forward completed Interview with attachments to:**

**HearPO Credentialing  
5000 Cheshire Lane North  
Plymouth, MN 55446  
763-496-0259-fax**



## 5.12 Contract Referral Form

HearPO negotiates contracts with many types of organizations including HMOs, PPOs, Unions, Employers, Insurance companies, and Medical groups. Please fill out this form completely when you identify a contract referral source and fax it to HearPO Customer Service at 763-268-4210.

**Date of referral:** \_\_\_\_\_

**Clinic location (city & state):** \_\_\_\_\_

**Provider Name:** \_\_\_\_\_

**Provider phone/fax/e-mail:** \_\_\_\_\_

**Name of organization:** \_\_\_\_\_

**Type:** HMO \_\_\_\_ PPO \_\_\_\_ Employer \_\_\_\_ Union \_\_\_\_ Other \_\_\_\_

**Contact name:** \_\_\_\_\_

**Contact phone:** \_\_\_\_\_

**Contact address:** \_\_\_\_\_

**Additional information:** \_\_\_\_\_

\_\_\_\_\_

**States covered:** \_\_\_\_\_

**Area covered:** \_\_\_\_\_

**Type of benefits:** Diagnostic? \_\_\_\_\_ Hearing Aids? \_\_\_\_\_

**How important is this contract to your clinic?** Very important \_\_\_ Neutral \_\_\_ Unsure \_\_\_

**How did you hear about this organization?** \_\_\_\_\_

\_\_\_\_\_

**HearPO Use Only**

Date Received: \_\_\_\_\_

## 5.13 Coding

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### Special Service

92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
92508	Group, two or more individuals. This is bundled with 92507
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming
92516	Facial nerve function studies (e.g., electroneuronography)

### Vestibular Function Tests

92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions, with recording
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Sinusoidal vertical axis rotational testing
92547	Use of vertical electrodes in any or all of above tests counts as one additional test
92548	Computerized dynamic posturography



## Audiologic Function Tests

The audiometric tests listed below imply the use of calibrated electronic equipment. All descriptors refer to testing both ears.

Note: Please use the modifier “-52” or 09952, if a test is applied to one (1) ear rather than two.

92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92553	Air & bone <b>This is bundled with 92553</b>
92555	Speech audiometry threshold;
92556	With speech recognition <b>This is bundled with 92555</b>
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92559	Audiometric testing of groups
92560	Bekesy audiometry; screening
92561	Bekesy audiometry; diagnostic <b>This is bundled with 92560</b>
92562	Loudness balance test, alternate binaural or monaural
92563	Tone decay test
92564	<b>Short increment sensitivity index (SISI)</b>
92565	Stenger test, pure tone
92567	Tympanometry (impedance testing)
92568	Acoustic reflex testing
92569	Acoustic reflex decay test
92571	Filtered speech test
92572	Staggered spondaic word test
92573	Lombard test
92575	Sensorineural acuity level test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92579	Visual reinforcement audiometry (VRA)
92582	<b>Conditioning play audiometry</b>
92583	Select picture audiometry
92584	Electrocochleography
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited <b>This is bundled with 92585</b>
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
92588	Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies) <b>This is bundled with 92587</b>
92589	Central auditory function test(s) (specify)



92590	Hearing aid examination and selection; monaural
92591	Hearing aid examination and selection; binaural
92592	Hearing aid check; monaural
92593	Hearing aid check; binaural
92594	Electroacoustic evaluation for hearing aid; monaural
92595	Electroacoustic evaluation for hearing aid; binaural
92596	Ear protector attenuation measurements
92597	Evaluation for use and/or fitting of voice device to supplement oral speech
92590	Hearing aid examination and selection; monaural
92591	Hearing aid examination and selection; binaural
92592	Hearing aid check; monaural
92593	Hearing aid check; binaural
92594	Electroacoustic evaluation for hearing aid; monaural
92595	Electroacoustic evaluation for hearing aid; binaural
92596	Ear protector attenuation measurements
92597	Evaluation for use and/or fitting of voice device to supplement oral speech

### **Other Procedures**

92700	Unlisted otorhinolaryngological service or procedure
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# HearPO

## ICD-9 Codes

Benign neoplasm of brain and other parts of nervous system, cranial nerves	225.1
Acquired deformities of auricle or pinna	380.32
Acute swimmers' ear	380.12
Adhesive middle ear disease, unspecified	385.10
Unspecified birth asphyxia in live born infant	768.9
Other anomalies of external ear with impairment of hearing	744.02
Barotrauma, otitic	993.0
Bell's palsy	351.0
Cerumen impaction	380.4
Cholesteatoma of external canal	380.21
Cholesteatoma of middle ear	385.32
Cleft palate with cleft lip, unspecified	749.20
Cleft palate, unspecified	749.00
Concussion, unspecified	850.9
Discontinuity of ear ossicles	385.23
Down's syndrome	758.0
Acute otitis external	380.22
Eustachian tube dysfunction	381.81
Facial nerve disorder	351.9
Fistula, labyrinthine dysfunction unspecified	386.50
Fistula, round window	386.41
Fistula, oval window	386.42
Fistula, semicircular canal	386.43
Foreign body in ear	931*
Hearing loss Unspecified	389.9
Central Hearing Loss	389.14
Conductive Hearing Loss, unspecified	389.0
Impairment of auditory discrimination	388.43
Mixed conductive & sensorineural hearing loss	389.2
Noise-induced hearing loss	388.12
Presbycusis	388.01
Sensorineural hearing loss, Unspecified	389.10
Sudden hearing loss, unspecified	388.2
Other specified forms of hearing loss	389.8
Hyperactive labyrinth bilateral	386.52
Hyperactive labyrinth unilateral	386.51
Hyperacusis	388.42
Hyperbilirubinemia, neonatal	774.6
Hypoactive labyrinth, bilateral	386.54
Hypoactive labyrinth, unilateral	386.53
Labyrinthitis	386.3*
Laceration Ear Canal	872.02
Laceration Ear Drum	872.61
Unspecified anomaly of ear	744.3
Other anomalies of external ear with impairment of hearing	744.02
Anomalies of inner ear	744.05
Mastoidectomy cavity, chronic	383.33
Postmastoidectomy complication, unspecified	383.30
Mastoiditis, unspecified	383.9



Meningitis, unspecified	322.9
Multiple sclerosis	340
Neurofibromatosis	237.7*
Noise induced hearing loss	388.12
Exostosis of external ear canal	380.81
Otalgia, unspecified	388.70
Infective otitis externa, unspecified	380.10
Other chronic otitis externa	380.23
Chronic mycotic otitis externa	380.15
Other and unspecified chronic nonsuppurative otitis media	381.3
Otorrhea	388.6*
Otosclerosis, unspecified	387.9
Perforation of tympanic membrane	384.2
Pinna, disorder of, unspecified	380.30
Accessory auricle	744.1
Prematurity Unspecified	765.00
Less than 500 grams	765.01
500-749 grams	765.02
750-999 grams	765.03
1000-1249 grams	765.04
1250-1499 grams	765.05
1500-1749 grams	765.06
1750-1999 grams	765.07
2000-2499 grams	765.08
2500 grams or more	765.09
Recruitment	388.44
Other speech disturbance	784.5
Development delayed speech	315.39
TMJ disorders	524.6*
Subjective tinnitus	388.31
Tympanosclerosis, unspecified as to involvement	385.00
Tympanosclerosis, involving TM only	385.01
Tympanosclerosis, involving TM & ossicles	385.02
Chronic ulceration of unspecified site	707.9
Dizziness and giddiness	780.4
Benign paroxysmal positional vertigo	386.11
Vertigo of central origin	386.2
Peripheral vertigo, unspecified	386.10
Meniere's Disease, unspecified	386.00
Otogenic vertigo or aural vertigo	386.19
Disorders of acoustic nerve	388.5

\* = Requires 4<sup>th</sup> or 5<sup>th</sup> digit which can be found in the ICD-9 code handbook

## HCPCS V-Codes

Please refer to the HCPCS Billing Procedure Code Book for proper coding.