HEARING CARE SOLUTIONS, INC.
(866) 344-7756

Hearing Care Solutions - Application | Provider Criteria

Thank you for taking the time to join the Hearing Care Solutions provider network; working to bring value and quality hearing to our patients. A participating provider must demonstrate satisfactory professional qualifications and a commitment to the quality standards and cost containment principles of HCS.

Each hearing care provider:

1. Possesses a graduate degree in Audiology (Master or Doctoral degree) from an accredited university, **or** holds state licensure as a Hearing Instrument Specialist.

2. Complies with all applicable licensure and registry requirements in each state where services are rendered.

3. In states where there is no audiology licensure requirement, provider has Board Certification in Audiology from the American Board of Audiology and/or Certificate of Clinical Competency in Audiology (CCC-A) from the American Speech-Language-Hearing Association (ASHA).

4. Maintains professional malpractice insurance with a minimum coverage of $1,000,000 per incident / $3,000,000 aggregate and an acceptable malpractice history.

5. Has an independent practice or practices as an employee of a physician, hospital, medical clinic, audiologist-managed corporation or another audiologist or hearing instrument specialist who satisfies Provider Criteria.

6. Agrees to adhere to the provider instructions and the corresponding HCS Approved Hearing Aids list.

7. Practices at a facility at which all necessary equipment for the evaluation of hearing and the dispensing of hearing aids is available and regularly calibrated. (Site Checklist attached)

8. Maintains regularly scheduled office hours at each facility where services are rendered.

9. Has completed and signed the Provider Application, Agreement, Site Checklist, and sent in office W-9, malpractice insurance, and applicable license(s) and/or certification(s). Below is a checklist to outline what HCS credentialing department needs to process your application.

For each provider, please submit these items to HCS:

- ☐ Hearing Care Solutions Provider Application (this application)
- ☐ Copy of higher education diploma (if applicable)
- ☐ Current state license, or board certification **with** expiration date
- ☐ Current certificate of Professional Liability (Malpractice) Insurance **with** expiration date
- ☐ W – 9 form
- ☐ Hearing Care Solutions Provider Agreement

~ **Please send your application and supporting documents to:** ~

applications@hearingcaresolutions.com

or via Fax: (888) 456-3047

Hearing Care Solutions – Application | Provider Information

Provider Details

Provider Name _____

Professional Title _____ NPI (National Provider Id) # _____

Provider Email _____ Date of Birth _____

Provider Cell _____ Social Security # _____

Professional Credentials

Professional Affiliations _____

Audiologist License # _____ Hearing Aid Dispensing # _____

Board Certified? Yes ☐ No ☐ Expiration Date _____

ASHA CCC-A Yes ☐ No ☐ Expiration Date _____

If Available: Medicare # _____ Medicaid # _____

Work History (Please provide work history for the **past 6 years**, any gaps exceeding 6 months provide an explanation.)

Place of Employment _____

From _____ To _____ Title _____

Responsibilities _____

Place of Employment _____

From _____ To _____ Title _____

Responsibilities _____

Have you ever been asked to resign or been terminated from any of the positions above?

No ☐ Yes ☐ (if yes, please provide explanation)

Additional work history please attach to this application

Education (To be filled out if you omit a copy of your degree / diploma)

Name of School _____

Highest Level ☐ High School ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

Graduation Date Month _____ Year _____

I, _____ understand that by not providing a copy of my degree / diploma with the HCS provider application, I am verbally verifying my degree is valid and that Hearing Care Solutions, Inc. may use this information for any credentialing needs. I attest this information is true and accurate to the best of my knowledge.

Signature of Provider _____ Date _____

Hearing Care Solutions – Application | Office Information

Office Details (For database accuracy, extra offices under the practice will need to fill out an additional office information sheet)

Practice Name _____

DBA Name (If different than above) _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Tax ID # _____

Fax _____ Website _____

Office Email _____

Location Information

Location Name _____

Providers at Office _____

Additional Languages ☐ Spanish ☐ Mandarin ☐ Hindi/Urdu ☐ Arabic ☐ French ☐ Other _____

Office Hours

Day	From	To
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Which manufacturers do you have an account with?

☐ Beltone ☐ Starkey
☐ Oticon ☐ Sonic
☐ Rexton ☐ Widex
☐ ReSound
☐ Siemens

Site Audit Checklist

This checklist ensures your office is compliant with ADA, NCQA, and CMS standards, please fill out and sign below.

Office Environment	☒ / ☐	Disability Access	☒ / ☐	Administrative	☒ / ☐
Office sign clearly visible	☐	Handicapped parking	☐	Patient info HIPPA compliant	☐
Adequate parking	☐	Path of travel to entrance clear	☐	Provider / operations manual	☐
Adequate seating in waiting room	☐	Man entrance door 32in clear open	☐	Licensed staff with certifications	☐
Accommodation for hearing impaired	☐	All wheelchair ramps accessible	☐	Medical records handled and stored	☐
Public restrooms available	☐	All rooms accessible for disabilities	☐	Confidentiality where appropriate	☐
Smoke detectors/alarms and sprinklers	☐	Public restrooms easily accessible	☐	Access and appointment system	☐
Emergency exits clearly visible	☐	Lavatory wheelchair accessible	☐	At least one staff member CPR cert.	☐
Fire extinguishers visible and checked	☐	Accessible stalls have grab bars	☐	Hearing aids cleaned after use	☐
Evacuation plan of action	☐	Lavatory rim no higher than 34in	☐	Clean and professional office	☐
Equipment cleaned daily	☐	Soap, skink, drier easily usable	☐	Elevators in facility ADA standardized	☐
Medical supplies marked and stored	☐	Mirror mounted 40in from floor	☐	(if applicable)	

Signature of Provider _____ Date _____

By signing above, the office confirms the results of the reviewer and any of the deficiencies will be met to the best of the practioners abilities to comply with CMS, Hearing Care Solutions and industry standards.

Service Details

Insurance Carrier _____

Amount Per Incident $_____ Aggregate $_____

Tinnitus Treatment ☐ Yes ☐ No Pediatric Services ☐ Toddlers ☐ Children

Compliance Check

1. Has your license to practice in any jurisdiction ever been limited, suspended, or revoked?	☐ Yes	☐ No
2. Have you ever been denied membership or renewal therof or been subject to disciplinary action in any medical organization?	☐ Yes	☐ No
3. Are you currently having any medical and/or physical problem(s) which would adversely affect your ability to practice?	☐ Yes	☐ No
4. Do you have any chronic illness and/or communicable infectious disease that may be a potential danger to patients?	☐ Yes	☐ No
5. Are you or have you been involved in a malpractice suit?	☐ Yes	☐ No
6. Has any malpractice carrier ever made an out-of-court settlement or paid a judgment on a professional liability claim on your behalf?	☐ Yes	☐ No
7. Has your malpractice coverage ever been denied or cancelled?	☐ Yes	☐ No
8. Are you currently under indictment for any crime?	☐ Yes	☐ No
9. Have you ever been convicted of or pleaded no contendere to a felony or other criminal offense, including, without limitation, a criminal offense related to Medicare, Medicaid, or any other federal program?	☐ Yes	☐ No
10. Have you ever been expelled, excluded, or suspended from any federal program of from service reimbursement under Medicare or Medicaid?	☐ Yes	☐ No
11. Do you have a history of chemical dependency/substance abuse or currently abuse drugs/alcohol?	☐ Yes	☐ No

If you answered YES to any of the above questions, please attach an explanation.

Applicants Statement

I certify that the answers given by me to the foregoing questions and statements are true and correct without any falsification, omissions, or misleading statements whatsoever. I agree that Hearing Care Solutions, Inc. shall not be held liable in any respect if my participation as a Provider is terminated because of false or misleading statements, answers or omissions by me in this application.

Signature of Provider: _____ Date: _____

Signature above gives permission to provide credentialing information to any contracted or designated third party insurance payor. Notice: You are advised that outside sources are queried during the credentialing process. You will have the right to review/correct any information discovered during this process. You should know that, under federal regulations, adverse credentialing decisions may be reported to certain national databanks (NPDB, HIPDB, EPLS, OIG).