nations hearing

Provider Network
REGISTRATION

PRACTICE INFORMATION

Legal Business Name (as appears on the W-9):

DBA:

Practice Type *(Please circle one):* Incorporated LLC PLLC Partnership Sole Proprietor
Other: ___________________

State of Incorporation:	**Federal Tax ID:**

What Hearing Aid Manufacturers do you work with? *(please check mark all that apply)*

☐ **Resound**	☐ **Beltone**	☐ **Starkey**	☐ **Phonak**
Ship to Acct #	Dispenser #	Ship to Acct #	Ship to Acct #
☐ **Oticon**	☐ **Unitron**	☐ **Widex**	☐ **Signia**
Ship to Acct #	Ship to Acct #	Ship to Acct #	Ship to Acct #

Type 2 NPI (Location NPI):	**Number of Service Locations:**

Address for Notice:

City:	**State:**	**ZIP Code:**
County:	**Phone:**	**Fax:**

Owner E-mail:

OWNERSHIP INFORMATION

Owner Name (Last, First):	**Ownership Percentage:**

Does this practice have any additional owners? *(Please circle one)* Yes No

If yes, please list below:

Owner 2 Name (Last, First):	**Ownership Percentage:**
Owner 3 Name (Last, First):	**Ownership Percentage:**

SERVICE LOCATION INFORMATION

LOCATION 1

Location Name:

Address:

City:	**State:**	**ZIP Code:**
County:	**Phone:**	**Fax:**

Location E-mail:

Office Contact Name:	**Office Contact Title:**
Office Contact Phone:	**Office Contact E-mail:**

Public Transportation Route Available? *(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? (*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:

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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 2

Location Name:

Address:

City:	**State:**	**ZIP Code:**
County:	**Phone:**	**Fax:**

Location E-mail:

Office Contact Name:	**Office Contact Title:**
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 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:

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 3

Location Name:

Address:

City:	**State:**	**ZIP Code:**
County:	**Phone:**	**Fax:**

Location E-mail:

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Office Contact Name:	**Office Contact Title:**
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 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:	
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 Title:**
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 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:	
Languages Spoken:	
Public Transportation Route Available? ***(Please circle one)*** Yes No	

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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 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:**	
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? (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

HEARING CARE PROFESSIONAL INFORMATION

TOTAL NUMBER OF HEARING CARE PROFESSIONALS (HCP) IN PRACTICE:

HCP 1 NAME (LAST, FIRST):

Individual NPI:	**CAQH ID:**
Medicare ID:	**Medicaid ID:**
Credentials ***(Please circle one):*** AuD MA/MS HIS HAS 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**	☐ **Location 3**	☐ **Location 4**	☐ **Location 5**
HCP 2 NAME (LAST, FIRST):				
Individual NPI:			**CAQH ID:**	
Medicare ID:			**Medicaid ID:**	
Credentials *(Please circle one):* AuD MA/MS HIS HAS 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**	☐ **Location 3**	☐ **Location 4**	☐ **Location 5**
HCP 3 NAME (LAST, FIRST):				
Individual NPI:			**CAQH ID:**	
Medicare ID:			**Medicaid ID:**	
Credentials *(Please circle one):* AuD MA/MS HIS HAS 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**	☐ **Location 3**	☐ **Location 4**	☐ **Location 5**
HCP 4 NAME (LAST, FIRST):				
Individual NPI:			**CAQH ID:**	
Medicare ID:			**Medicaid ID:**	
Credentials *(Please circle one):* AuD MA/MS HIS HAS 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**	☐ **Location 3**	☐ **Location 4**	☐ **Location 5**
HCP 5 NAME (LAST, FIRST):				
Individual NPI:			**CAQH ID:**	
Medicare ID:			**Medicaid ID:**	
Credentials *(Please circle one):* AuD MA/MS HIS HAS HAD Other: ______________________				
Gender:			**Languages Spoken:**	
Phone:			**E-mail:**	
Total Number of Locations Assigned:				

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Please check mark all locations assigned to HCP from the list above				
☐ Location 1	☐ Location 2	☐ Location 3	☐ Location 4	☐ Location 5
HCP 6 NAME (LAST, FIRST):				
Individual NPI:		**CAQH ID:**		
Medicare ID:		**Medicaid ID:**		
Credentials *(Please circle one):* AuD MA/MS HIS HAS 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	☐ Location 3	☐ Location 4	☐ Location 5
HCP 7 NAME (LAST, FIRST):				
Individual NPI:		**CAQH ID:**		
Medicare ID:		**Medicaid ID:**		
Credentials *(Please circle one):* AuD MA/MS HIS HAS 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	☐ Location 3	☐ Location 4	☐ Location 5

OWNER ATTESTATION

1. Is your current business compliant with all current HIPAA/HITECH rules and regulations? (*Please check mark one*):

☐ 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? (*Please check mark one*):

☐ Yes ☐ No ☐ 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)? (*Please check mark one*):

☐ 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? (*Please check mark one*):

☐ Yes ☐ No ☐ N/A

5. Have you ever had any professional liability actions settled, arbitrated, mediated or litigated? (*Please check mark one*):

☐ 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? (*Please check mark one*):

☐ Yes ☐ No ☐ N/A

7. Has the business owner(s) ever been convicted of or pled guilty to a felony? (*Please check mark one*):

☐ Yes ☐ No ☐ N/A

8. Has your business license ever been voluntarily or involuntarily relinquished, denied, suspended, revoked or restricted? (*Please check mark one*):

☐ 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.

______________________________ ________________

Signature **Date**

____

Printed Name