11480 Commerce Park Drive
Suite 220
Reston, VA 20191

tel 800-AAA-2336
fax 703-790-8631
www.audiology.org

Hearing Aid Insurance Verification Worksheet

Date______________________________

Patient Name: ____ Patient DOB ____

Insured's Name: ____ Insured's DOB _______________________________________

Insurance Company ______________________________________ Policy Number ______________________________________

Representative _______________________________________ Reference #____

Primary Secondary Tertiary Participating Provider: Yes No In Network Provider: Yes No

What is the allowable benefit? $______________________ How much of it has been used to date? _____________________

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

Will a specific type of hearing aid realize their maximum benefit? Yes No If yes, what type?____________________

What is the out of network benefit (if not an in network provider):____
Is the hearing aid benefit: Monaural/Binaural Annual Every: 2 years 3 years 5 years

Is benefit applied to usual and customary or allowed amount? Yes No Anticipated write off: $________________

Is a provider discount required? Yes No If yes, what is the amount of the discount? __________________

Patient Responsibility

Deductible__________________ When was it met?________________ Co-Pay______________________ Co-Insurance ___________________________

Plan Requirements (check if required)

☐ Prior Authorization ☐Medicare denial ☐ Referral ☐ Prescription ☐ Medical Clearance ENT Only? Y /N

☐ Actual invoice required ☐ Other: ____

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

Hearing Aid Code(s) ___________________________ Professional Fee Code(s) ___________________________

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

Other: ____

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