PROVIDER INFORMATION SHEET

Audiological Services and Hearing Aid Funding

FACILITY

Name: _____

Address: _____

Tax ID Number: _____

Contact Person: _____ **Title:** _____

Telephone: _____ **E-mail address:** _____

BILLING INFORMATION –AS PRINTED ON THE CLAIM

Name: _____

Address: _____

Contact Person: _____ **Title:** _____

Telephone: _____ **E-mail address:** _____

INDIVIDUAL HEALTH CARE PROVIDERS

Enter professionals' employed/paid by facility that may provide services to children with Audiological funding.

PROVIDER NAME	MEDICAID PROVIDER?		NPI NUMBER
	YES	NO	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

_____ _____

Signature of Facility Representative Date

By accepting payments based on Iowa Medicaid rates for services covered by this program, you are agreeing to consider this payment as payment in full with required provider liability and further agree to not bill the patient for remaining balances on covered services.

Submit to:

NORTH IOWA COMMUNITY ACTION

HEARING AIDS AND AUDIOLOGICAL SERVICES PROGRAM

PO BOX 1627

MASON CITY, IOWA 50402-1627

Phone/Fax: (641) 424-8006