IOWA | Health and Human Services

Hearing Aid and Audiological Services Funding

PROVIDER INFORMATION SHEET

FACILITY

Name: _____

Address: _____

TAX ID Number: _____

Contact Person: _____ **Title:** _____

Email: _____ **Phone:** _____

BILLING INFORMATION – AS PRINTED ON THE CLAIM

Name: _____

Address: _____

Contact Person: _____ **Title:** _____

Email: _____ **Phone:** _____

INDIVIDUAL HEALTH CARE PROVIDERS

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

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

IOWA | Health and Human Services

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

_____ _____

Signature of Facility Representative **Date**

Submit to:
North Iowa Community Action Organization
Hearing Aids and Audiological Services Program
PO Box 1627
Mason City, IA 50402-1627

Phone: 641-424-8006
Fax: 833-536-1806