Great Lakes
Provider Network, LLC
an AudioNet company

Claim Worksheet

PATIENT INFORMATION

Name: _____ Member/ Customer ID: _____
Address: _____ Date of Birth: _____
City, State, Zip: _____ Telephone: _____
AudioNet Group Name: Select _____ Gender: ☐ Female ☐ Male

PATIENT INSURANCE INFORMATION

Is there Primary Insurance for Hearing Aid Benefits? (*Voc Rehab only*) ☐ Yes ☐ No Plan Name: _____

PROVIDER INFORMATION

Facility Name: _____ Provider Name: _____
Facility Address: _____ Provider NPI: _____
City, State, Zip: _____ Submitted by: _____
Office Phone #: _____ Email: _____

AUTHORIZED SERVICES

Please check all services that apply and submit one worksheet per Authorization number.

☐ **Right Ear** ☐ **Left Ear** ☐ **Both Ears**

Authorization #: _____ **Diagnosis Code:** _____

☐ **S0618 - Audiometry for Hearing Aid Evaluation** **Date of Service:** _____
☐ **V5010 - Assessment for Hearing Aid Devices** **Date of Service:** _____

Hearing Aid Devices

☐ **V5221 - Hearing Aid Device, CROS/BiCROS, (BTE/BTE)**
☐ **V5254 - Hearing Aid Device, Monaural, CIC**
☐ **V5255 - Hearing Aid Device, Monaural, ITC**
☐ **V5256 - Hearing Aid Device, Monaural, ITE**
☐ **V5257 - Hearing Aid Device, Monaural, BTE/RIC**
☐ **V5258 - Hearing Aid Device, Binaural, CIC**
☐ **V5259 - Hearing Aid Device, Binaural, ITC**
☐ **V5260 -Hearing Aid Device, Binaural, ITE**
☐ **V5261 -Hearing Aid Device, Binaural, BTE/RIC**
☐ **Other -** _____

Dispensing

☐ **V5200 - Dispensing Fee, CROS - Monaural Fee**
☐ **V5240 - Dispensing Fee, BiCROS - Binaural Fee**
☐ **V5241 - Dispensing Fee, Monaural Hearing Aid Device**
☐ **V5160 - Dispensing Fee, Binaural Hearing Aid Device**
☐ **Other -** _____

Date of Service: _____

Conformity Evaluation

☐ **V5020 - Conformity Evaluation**

Date of Service: _____

Modifiers: ☐ **Mid** ☐ **Mid-High** ☐ **Advanced** ☐ **Flagship**

For a complete list of HCPCS codes, please reference the Provider Manual.

REQUIRED DOCUMENTS

☐ **Audiogram**
☐ **Confirmation of Delivery Form**
☐ **Total Patient Copay** $ _____
☐ **Medical Clearance** (***If applicable***)
☐ **Remittance Advice** (***If applicable***)

PROVIDER VERIFICATION AND SIGNATURE

I certify that the services listed above were authorized and necessary to the health of the patient and were personally furnished by me. I further certify that I have billed the Patient's insurer for any available benefits for the services provided, if applicable.

Provider Signature: _____ **Date Submitted:** _____