Great Lakes Provider Network, LLC
an AudioNet company

Claim Worksheet

PATIENT INFORMATION

Name: Marjorie Richardson
Address: 913 Willowbrook Blvd
City, State, Zip: York, PA 17405
AudioNet Group Name: Geisinger - Medicare Advantage

Member/ Customer ID: 10087442951
Date of Birth: 6/16/1951
Telephone: 717-555-6543
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: Plante Hearing Center
Facility Address: 226 Finwood Rd
City, State, Zip: West York, PA 17404
Office Phone #: 717-221-5951

Provider Name: Thomas Plante, AuD
Provider NPI: 1275440353
Submitted by: Mary Smith, Office Manager
Email: mary@plantehc.com

AUTHORIZED SERVICES

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

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

Authorization #: 2003060891 **Diagnosis Code:** H90.3

☑ **S0618 - Audiometry for Hearing Aid Evaluation** **Date of Service:** 1/4/2021
☑ **V5010 - Assessment for Hearing Aid Devices** **Date of Service:** 1/4/2021

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: 1/11/2021

Conformity Evaluation

☑ **V5020 - Conformity Evaluation**

Date of Service: 1/19/2021

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** $ 1000
☐ **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: Thomas Plante, AuD **Date Submitted:** 1/19/2021