VIRSONO
Hearing Center

Tax-ID: 85-3162609
Group NPI: NONE
Please see facesheet for address and NPI

Location (City, State): _____ Provider Name: _____

PATIENT NAME: _____ **DOB:** _____ **APPT:** _____

INSURANCE: _____ **INS PHONE:** _____

ID#_____ **GROUP** _____ **PLAN TYPE** _____

IN NETWORK OR OUT OF NETWORK(**) : NO OUT OF NETWORK BENEFITS _____

IF SUPPLEMENT, DOES PLAN FOLLOW MEDICARE GUIDELINES: YES OR NO

INDIVIDUAL DEDUCTIBLE $_____ **MET $**_____

FAMILY DEDUCTIBLE $_____ **MET $**_____

INDIVIDUAL OOP $_____ **MET $**_____

FAMILY OOP $_____ **MET $**_____

DR REFERRAL REQUIRED Y OR N PRE-AUTH REQUIRED Y OR N

IF YES, PHONE NUMBER TO ACQUIRE PRE-AUTH: _____

HEARING AID BENEFIT:

COVERAGE AT _____**% of allowable Does Deductible Apply? Y or N**

MAX BENEFIT _____ **Per Ear or Total HOW OFTEN** _____

ELIGIBLE NOW: Y OR N IF NOT, DATE ELIGIBLE: _____

3RD PARTY OPTION: Y OR N NAME & PHONE: _____

Same for IN and OUT of network? Y OR N _____

CIRCLE IF CODES ARE VALID & BILLABLE:

V5261 V5257 V5110 V5256 V5264 V5090 V5275

INS REP: _____ **REF#**_____

HBS Rep: _____ **Date & Time:** _____

Length: _____