

Funding Questionnaire
Please complete this form and return it with your funding request.

Employer's Name or School name _____

License #:

Speech Language Pathologist or other source of formal Evaluation:

Name: _____ Telephone #: _____
Address: _____ Fax #: _____

City State Zip Code Email: _____

Contact Person: It is often very helpful for you to have someone as your designated advocate. This person is in addition to the SLP. It should be someone who knows you well.

Name: _____ Telephone #: _____
Address: _____ Fax #: _____

City State Zip Code Email: _____

Applicable Funding Sources Information

Include all funding sources and insurances by which the client is covered. If an applicable source has been contacted and a denial received, the information regarding that source must be provided below and a copy of the denial attached to the funding package.

Please attach clear copies of the most current funding source card(s), both front and back.
Check all that apply:

Medicaid/Medical Assistance Recipient ID# (This includes Title XIX) # _____ # _____ Is client part of a Managed Care Program Through Medicaid/Medical Assistance? ☐ Yes ☐ No If yes, complete the information below where indicated .(◆)	Medicare # CHAMPUS/Military Coverage(◆) Private, Group or Commercial Insurance/HMO(◆). (◆) Indicates to complete the section below with the information pertaining to specific funding source as checked.
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Complete the following information if you have checked a source with the Following
Notation (◆)

Name Of: Private, Group or Commercial Insurance/HMO, Medicaid/Medical Assistance
Managed Care Program or CHAMPUS (If necessary attach an extra page and indicate
primary, secondary, etc.)

Requested Equipment/ Recommended Equipment

Please be very specific when listing the equipment below.

Please call Hearit at 1-800-298-7184 if advice or assistance is needed.

CATALOG PART #	PRODUCT DESCRIPTION	PRICE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Shipping Information

Please provide a complete street address as items cannot be shipped to a Post Office box.

A phone number with area code is also necessary.

Address _____

Attention: _____ Phone: _____

A word from Hearit

This Funding Questionnaire is used to facilitate the funding process through Hearit LLC and the Applicable fund source(s). The information given will be used to secure funding through the applicable funding sources only. All requested information is necessary to complete the funding process from initial request(s) to submitting the billing/claim(s). Missing Information will result in processing delays. To ensure timely processing, please complete the entire Funding Questionnaire. If you have any questions please contact the Hearit at 1-800-298-7184.

I verify that all information contained is correct and true to the best of my knowledge.

Signature of Person(s) completing this form

Date