



Hearit LLC
8346 N. Mammoth Dr.
Tucson, AZ 85743
Tel: 1-800-298-7184
Fax: 520-579-3368

TEXAS FUNDING CHECK LIST

The Funding Check List is a way to verify that all necessary information required to submit for funding to: Medicaid, Private Insurance, CHAMPUS / Military Insurance and Medicare is included within the Funding Package. All requested documents are necessary. Missing information will result in processing delays. The funding sources mentioned above have strict guidelines which must be followed. Hearit is simply reinforcing those guidelines in an attempt to reduce denials and delays. Hearit is required to keep a copy of all documentation on file for possible audits by the applicable funding source(s). However, a copy should be kept by both the client advocate and client contact. Both the client advocate and client contact will receive notification from Hearit when the request has been submitted to the applicable source(s). Many thanks from the funding staff at Hearit for your cooperation and patience.

Required Documents / Information (Documentation should not be more than six to eight months old)

(Please mark off all enclosed documentation/information and attach to the Funding Package.)

Hearit Funding Questionnaire (3 completed pages) (FQ - 6/98) (enclosed)

Clear and current copies of the client's applicable funding source card(s)
(Medicaid, Private Insurance, CHAMPUS/MI and Medicare)

- If requesting funding from Texas Medicaid, the following documentation is needed:

Refer to the Texas Augmentative Communication Device Policy Requirements (enclosed)

Completed THSteps-CCP Prior Authorization Request (PAR) form (enclosed)

Note: The (PAR) form is to be partially completed by the Physician.

The Physician should complete the following: Client Medicaid Number, Name, Address, DOB & Age; Item or Service Requested and Manufacturer Name/Model only (Enter the name of the exact equipment including device and accessories — Hearit products only!). This form needs a live signature at the bottom.

Incorrectly completed (PAR) forms will be returned for proper completion!

- If requesting funding from a source other than Texas Medicaid, the following documentation is needed:

Physician's Prescription and/or written order (Should specify "EXACT" Equipment)

Comprehensive Speech/Language Evaluation(s)

Augmentative Communication Evaluation(s)/Assessment(s) (Can be part of a Speech / Language Evaluation

Letter(s) of Medical Necessity / Support (We recommend a minimum of two)

[From: Speech, Occupational and/or Physical Therapist(s), Nurse(s), Physician(s), Psychologist(s), Psychiatrist(s), Teacher(s), Case Worker(s) and other Caregiver(s)]
(Should specify "EXACT" Equipment)

Additional Documentation / Information (when applicable)

Letter(s) of denial from Funding Sources already contacted for coverage of the equipment being requested

Completed Rental Contract (Must be signed)

Note: MOST FUNDING SOURCES WILL NOT SIGN THE RENTAL CONTRACT!

Send the completed funding package to:

Hearit LLC • 8346 N. Mammoth Drive • Tucson Arizona 85743

If faxing information, please follow up with the original documents via mail.

FUNDING QUESTIONNAIRE

Client Information (The client is the individual for which funding is being pursued)

Last Name _____ First Name _____

Address _____ Phone _____

C/S/ZIP _____ SSN _____

County of Residence _____ Sex Male or Female

Primary Diagnosis _____ Diagnosis Code _____

Secondary Diagnosis _____ Diagnosis Code _____

Is Diagnosis a result of accident? Yes or No

If yes: Date of accident? _____

Type of Accident? Auto Employment Other

Place of residence? Home Group Home Nursing Home Long Term Care Facility
Other

Hearit requests that you supply us with both a Client Contact and Client Advocate.
Both parties will receive ongoing notification from Hearit with regards to the funding request.

Client Contact Information (The client contact is the individual representing the client in a Non-professional manner)

Relation to client: Parent Guardian Spouse Other _____

Last Name _____ First Name _____

Address _____ Home Phone _____

_____ Work Phone _____

C/S/ZIP _____ FAX _____

Client Advocate Information (The client advocate is the individual representing the client in a professional manner)

Relation to client: Speech Pathologist Case Manager Other _____

Last Name _____ First Name _____

Address _____ Home Phone _____

_____ Work Phone _____

C/S/ZIP _____ FAX _____

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.

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.)

Pre-Authorized/Pre-Determination (of Benefits)
Address

Billing/Claims Address

Contact Person _____

Eligibility Phone # _____

Contact Phone # _____

Benefits Phone # _____

Contact Fax # _____

Billing/Claims Fax# _____

Policy Holder/Subscribe/Insured _____

Phone # _____

Policy Holder Address _____

SSN of Policy Holder _____ Name of Employer _____

Policy #/Agreement #/ Contract ID#/Recipient ID# _____

Group # _____ Policy Holder Relation to Client _____

Name and phone # of PCP/PCC (if applicable) _____

Referring Physician Information

The referring physician is the medical doctor who has prescribed the requested equipment. If the client has a Primary Care Physician/Clinician (PCP or PCC), and the PCP/PCC is not the referring physician, please contact Hearit.

Does the client have a PCP/PCC? Yes or No If yes, is the referring physician listed below the PCP/PCC? Yes or No

Physician Name _____

Address _____ Phone # _____

_____ Fax # _____

C/S/ZIP _____ License # _____

UPIN ("Universal Personal Identification Number" – One Letter with 5 digits) _____

Medicaid Provider # _____ Referral Number (if applicable) _____

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