BIG SKY **AUDIOLOGY** LLC

Experience Life's Moments

Patient Information

111 S. 24th St. W. • Unit 7 • Billings, Montana 59102 | P: 656-2003 • www.bigskyaudiology.com

Patient Name: (Last) (First) Date:

Mailing Address: Apt/Suite:

City: State: Zip:

Email: Occupation:

Home Phone: Cell Phone:

Work Phone: Marital Status: Married ☐ Single ☐ Widowed ☐

D.O.B.: / / Age: Gender: M ☐ F ☐ Name of Spouse

SS#: - - Primary Care Physician

How did you hear about us?

Referred by Physician: Website ☐ Mail ☐

Referred by Friend/Family: Newspaper ☐ Other

Patient Agreement

☐ **POLICY**

We participate in several different insurance plans including Medicare. We will gladly bill your insurance or provide you with the necessary documents, requested by the insurer for reimbursement. You are financially responsible for any equipment or services that are not covered by your insurance. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered Medically necessary under the Medicare program or by other insurance companies. You will be responsible for co-payment, deductibles or any portion not reimbursed by your insurance plan. Payment is expected at time of service. Financing is available for those that qualify.

☐ **INSURANCE AUTHORIZATION**

I hereby authorize direct payment of insurance benefits be made on my behalf to Big Sky Audiology Clinic, LLC. for examination, treatment or device delivery to me at the rate not to exceed Big Sky Audiology, LLC, usual charges. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services, be released to Big Sky Audiology Clinic, LLC. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment.

☐ **AUTHORIZATION TO RELEASE MEDICAL RECORDS**

I give permission to Big Sky Audiology Clinic, LLC to release information, verbal and written, contained in my medical records and other documents to attorney(s), and/or my insurance carrier(s), and/or the referring and/or family physician, and/or school personnel such medical information as they may require or request.

☐ **ACKNOWLEDGEMENT OF RECEIPT of NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the office of Big Sky Audiology Clinic, LLC. I further acknowledge that a paper copy of this notice will be made available to me at my request.

☐ **AUTHORIZATION TO CONTACT**

I hereby authorize Big Sky Audiology Clinic, LLC to contact me by mail, email or phone, to inform me of scheduled appointments, follow-up appointments or to keep me updated on technology and service advances in the hearing field.

☐ I have read all the information on this sheet, have provided the requested information and certify this information is true and correct to the best of my knowledge. I agree to accept financial responsibility for goods and services rendered and to except the terms of the agreement listed above.

Signature_____ Date _____

Signature_____ Date _____

SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR

BIG SKY **AUDIOLOGY** LLC

Experience Life's Moments

Patient Insurance Information

111 S. 24th St. W. • Unit 7 • Billings, Montana 59102 | P: 656-2003 • www.bigskyaudiology.com

Patient Name: _____ (Last) _____ (First) D.O.B.: ___ / ___ / ___

Name of insured if different than patient: _____ D.O.B.: ___ / ___ / ___

Does the patient have Medicare? **Yes / No** Are you prim? **Yes / No** Do you require a denial? **Yes / No**

Insurance plan: _____ ID#: _____ Group: _____

Insurance plan: _____ ID#: _____ Group: _____

Insurance company contact: _____ Phone: _____

Date: _____ Time: _____ Is patient eligible? **Yes / No** Date of eligibility? _____

Is there a deductible or co-pay? **Yes / No**

If yes, what is the deduct/copay? _____

Has it been met for this coverage period? **Yes / No**

What is remaining? _____

Is an insurance referral needed? **Yes / No**

Are we a participating provider in this plan? (Tax ID# 84-4275105) **Yes / No**

Is there a hearing aid benefit available through this office? **Yes / No**

Is there a hearing aid benefit? **Yes / No** Are there any age restrictions in order to receive the benefit? **Yes / No**

Frequency of benefit: _____ Aid(s) per _____ Mo/Yr

Is a PA required? **Yes / No**

Do we have to provide provider discounts? **Yes / No**

If so, what is the discount? _____

Is there a max coverage or defined dollar amount? _____

If the insurance plan cannot provide specific types of aid or dollars covered, assume the coverage is $500 per ear or $100 max binaural.

Can the patient be balance billed for the difference between the coverage amount or negotiated rate and our standard "usual and customary" charge? **Yes / No**

Can the patient "upgrade", paying the difference? **Yes / No**

If yes, does this need to be in writing? **Yes / No**

Is this plan member submit? **Yes / No**

Is there hearing aid history? **Yes / No**

Can I bill separately for the hearing aid evaluation? 92590 or V5010 **Yes / No**

Can I bill separately for the dispensing fee? **Yes / No**

Do I bill binaural set as binaural; V5261 or 2 Monaural V5257? _____

If mono, do I need to use RT or FT modifiers? **Yes / No**

BIG SKY **AUDIOLOGY** LLC
Experience Life's Moments
111 S. 24th St. W. • Unit 7 • Billings, Montana 59102 | P: 656-2003 • www.bigskyaudiology.com

ARE THE FOLLOWING CODES COVERED ON THIS MEMBERS PLAN? ARE THESE INCLUDED IN THE AMOUNT OF THE HEARING AID BENEFIT? OR CAN THEY BE BILLED SEPARATELY AS WELL?

V5266–Batteries		**VNG CODES**	
92592/92593/V5011 HA Check		92540-Basic Vestibular Assessment	
92595/V5020 Conf. Eval		92541-Spontaneous Nystagmus	
92557 Audio/Test (Yrly Also)		92542-Positional Nystagmus Test	
92625 Tinnitus Assessment		92543-Caloric Vestibular Test	
		92544-Opeokinetic Nystagmus Test	
		95992-Canailth Repositioning, per visit	

Notes:

Can I have a reference number for this call?	

Where should I submit this claim?