Professional Application

START HEARING

All fields in this form must be filled out for each hearing professional. Submission of this application and responses does not guarantee acceptance into network.	
DATE:	
NAME:	TITLE:
MAIDEN/FORMER/OTHER NAME(S):	
DATE OF BIRTH:	PHONE NUMBER:
INDIVIDUAL NPI NUMBER:	
*CAQH ID # *If you do not have a CAQH profile, please log onto proview.caqh.org/login to create your profile.	

LICENSE NUMBER:		STATE:	EXPIRATION DATE:
LICENSE TYPE:	☐ Au.D. ☐ HIS/HAD/HAS	CERTIFICATION TYPE:	☐ CCC-A ☐ BC-HIS

Email Address Information:

We are capturing 2 email addresses. One for all communication and one for the provider portal. Provider portal emails will be used for logins and must be unique to provider.

COMMUNICATION EMAIL:
PORTAL EMAIL:

Please list all offices to which you are credentialing:

DISPENSING LOCATION: (ADDRESS)
DISPENSING LOCATION: (ADDRESS)
DISPENSING LOCATION: (ADDRESS)
DISPENSING LOCATION: (ADDRESS)

**We will accept a roster with all required fields of the application vs. filling out an application for each servicing location and/or Provider*