Membership Application

(Please fill out form completely)

Providers Name: _____

Please Select: ☐ AUDIOLOGIST ☐ HEARING INSTRUMENT SPECIALIST

Practice Name: _____

Address: _____ Telephone: (___) _____

_____ Fax Number: (___) _____

E-Mail: _____ County: _____

CREDENTIALS

Highest Degree (please circle one): BA/BS MS/MA PhD AUD Other: _____

Institution & Location: _____

AUDIOLOGY LICENSURE State: _____ Licensure #: _____ Exp. Date: _____

HEARING AID LICENSURE State: _____ Licensure #: _____ Exp. Date: _____

Provider NPI # (required) : _____ Site NPI # (required) _____

Medicare UPIN: _____ Medicaid #: _____ State: _____

Business License #: _____ State: _____

PRACTICE PROFILE

Number of years practicing audiology: _____ Numbers of years dispensing: _____

Corporate affiliations or franchise relationship: _____

Total number of sites within practice: _____ Total number of sites you visit: _____

What hearing aid manufacturers do you primarily dispense: _____

_____

How would you classify your dispensing site (please circle one):

1) Hearing Aid Office/Store
2) Family Doctor's Office
3) Audiology Practice
4) Hospital
5) ENT Office
6) Clinic of HMO
7) Other (specify): _____

I hereby authorize HearPO to review all credentials with the appropriate governing board. I also understand that submission of this application does not guarantee provider status, nor does it constitute HearPO acceptance of such status.

Applicant's signature: _____ **Date:** _____

Send completed application and attachments to:

HearPO Credentialing
5000 Cheshire Lane North
Plymouth, MN 55446
Fax: 763-496-0259