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|  | DIVISION OF VOCATIONAL REHABILITATION (DVR)  **Cost Estimate Worksheet for  Hearing Aids and Services** | | | |
| CUSTOMER’S NAME | | DATE OF BIRTH | | |
| SERVICE PROVIDER’S NAME | | TELEPHONE NUMBER (AND AREA CODE) | | |
| VOCATIONAL REHABILITATION COUNSELOR’S NAME | | | | |
| CURRENT PROCEDURAL TERMINOLOGY (CPT) TOTALS  **Hearing Aids** – Make and model:  $  Unit Needed:  Left Unit  Right Unit  Both Units  Features:  Bluetooth  Telecoil  Rechargeable Technology Level:  Essential  Standard  Advanced  Premium  **Accessories**: Ear molds / impressions, etc. $  Batteries (please specify supply amount): ) $  **Hearing Aids Fitting and Check** –  hours @ $= $  Please explain if additional hours are needed @ $/ hour for  **Reasons additional hours are needed**. $  **Assistive Listening Device – FM Consultation**: Pairing with smartphone, use of  telecoil, loops, FM systems, microphone, etc.)   @ $per ½ hour (maximum $) $  **Miscellaneous Services**: Please describe below, including item or service, length of  time, quantity, cost, etc. as applicable $ | | | | |
| Insurance Provider:  Warranty Details:  Loss / Damage Deductible Amount:  Insurance Benefit Amount: - $   (DEDUCT)  **TOTAL** $**0.00**  **Comments and Recommendations** - Please include:   * What has changed since the last evaluation? * What is the justification for recommending a particular type of hearing aid, and/or upgrade and/or repair? * If hearing aids and services are bundled, please clarify services included with the costs. | | | | |
| If additional space is needed, please continue on another page.  DVR has not agreed to payment until the Vocational Rehabilitation Counselor has signed this estimate. | | | |
| AUDIOLOGIST OR OTHER DVR APPROVED MEDICAL PROFESSIONAL’S SIGNATURE | | | DATE |
| CUSTOMER’S SIGNATURE | | | DATE |
| VOCATIONAL REHABILITATION COUNSELOR’S SIGNATURE | | | DATE |