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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 [ ]  RechargeableTechnology 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.
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| 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 |