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|  |  DIVISION OF VOCATIONAL REHABILITATION (DVR) **Cost Estimate Worksheet for Cochlear Implants** |
| 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 **Cochlear Implant** – Make and model:  $  Unit Needed: [ ]  Left Implant [ ]  Right Implant [ ]  Both Implants [ ]  Left Processor [ ]  Right Processor [ ]  Both Processors Features: [ ]  Bluetooth [ ]  Auracast [ ]  Rechargeable **Accessories**: Disposable batteries (please specify supply amount ) $  Rechargeable battery pack (please specify supply amount): ) $  **Cochlear Implant Basic Fitting and Check** –  hours @ $= $ Please explain if additional hours are needed @ $/hour for **Reasons additional hours are needed**. $  **Assistive Listening Device–Consultation**: Pairing with smartphone / Bluetooth app, 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 cochlear implant, and/or upgrade and/or repair?
* If cochlear implant and services are bundled, please clarify services included with the costs.
* If the timeline from initial cochlear implant evaluation through post-surgical sound mapping is anticipated to be longer than 12 months, please provide an explanation.
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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 |