|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 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. | | | | |
| 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 |