UTAH DEPARTMENT OF HEALTH

CHILDREN'S HEARING AID PROGRAM (CHAP) UCA 26-10-11
PAYMENT REQUEST COVER SHEET

Reset Form

CHILD (please do not put child's name on form)

Assigned CHAP # (UDOH to fill out box)	Managing Audiologist Name	Clinic	Date

REQUESTING AGENCY/CLINIC/DESIGNEE (who check should be made out to and where it should be sent)

Agency/Clinic		Dept (Attn:)		
Address		City	State	Zip
Contact Person for Questions	Phone	Email		

Documentation must be submitted <u>within 30 days of fitting</u> to:

Utah Department of Health
CHAP
PO Box 144620
Salt Lake City, Utah 84114-4620
Fax (801) 584-8492

For additional information, please contact:

Jenny Pedersen, AuD
(801) 584-8215
chap@utah.gov

Reimbursement details:

Hearing Aid invoice (MUST BE ATTACHED)	$
40% of Hearing Aid invoice amount =	$
Reasonable and customary* fees *<u>for hearing aid fitting and one year of follow-up services:</u>* **(REAL-EAR MEASUREMENT FOR FITTING MUST BE ATTACHED)**	$
Earmold invoice (MUST BE ATTACHED):	$
Reasonable and customary* fees *<u>for ear mold fitting:</u>* **(*CLINIC HEARING AID/EARMOLD FEE PRICE SHEET MUST BE ATTACHED)**	$
TOTAL REQUESTED	$ 0.00

As the managing audiologist, I certify that the documentation and request for payment represent accurate and appropriate services provided per UCA 26-10-11.

Managing Audiologist Signature	Date
CHAP Authorized Signature	Date
Additional Information Required (for office use only)	

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