



# Georgia Lions Lighthouse Foundation

*Better Vision. Better Hearing. Better Georgia.*

## Georgia Lions Lighthouse Foundation Hearing Program Provider Agreement & Standards

### I. Services

#### The Provider:

- A. The Provider agrees to provide the following services to Lighthouse clients for \$175 reimbursement per client from the Georgia Lions Lighthouse Foundation:
  1. Taking Ear Impressions
  2. Ordering Earmold(s) and Hearing Aid(s)
  3. Dispensing Appointment
  4. Two Follow-Up Visits
- B. The Provider agrees not to collect payment from the client for the above listed services offered by the Georgia Lions Lighthouse Foundation.
- C. The Provider agrees to be contact person for repair issues.
- D. The Provider agrees to charge \$25 for repair office visits. The Lighthouse Foundation will handle actual repair charges with the client.
- E. Provider reimbursement for replacement fittings will be \$80.

#### The Georgia Lions Lighthouse Foundation:

- A. The Lighthouse agrees to approve clients who meet the following requirements:
  - Household income less than 200% of the Federal Poverty Guideline
  - Georgia resident for more than one year
  - Have a hearing test (audiogram) less than six (6) months old
- B. The Lighthouse agrees to provide new digital hearing instruments with a three year repair warranty and a one-time loss/damage warranty within the first year of ownership.
- C. The Lighthouse agrees to offer free advertisement in our monthly Beacon newsletter, spotlights on our website, stories in your local newspaper, and marketing opportunities at our community events.
- D. The Lighthouse agrees to educate clients on the hearing program process and remedy any situation that may arise regarding the program and/or its processes.
- E. The Lighthouse agrees to be the contact person for replacement issues.

### II. Provider Reimbursement

#### The Provider:

- A. The Provider agrees to submit an invoice and verification of fitting (printout of Real Ear, functional gain, or similar measurement) as a form of payment invoice to the Georgia Lions Lighthouse Foundation after the dispensing appointment.
- B. Reimbursement checks must be deposited or cashed within 60 days of issue or they will be voided.
- C. The Provider agrees to submit invoices and verification of fitting within 120 days of the date of service.
- D. The Provider agrees to submit the fitting survey after the patient's final follow-up visit. If the patient does not attend any follow-ups, please notify the Lighthouse Foundation.



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## **The Georgia Lions Lighthouse Foundation:**

- A. The Lighthouse agrees to submit reimbursement after receipt of Provider invoice and fitting verification.
- B. The Lighthouse agrees to issue reimbursement within two (2) weeks of receiving Provider invoice and verification of fitting.
- C. The Lighthouse agrees to include patient names and dates of birth in the check memo section.

## **III. Term and Termination**

This Agreement shall commence as of \_\_\_\_\_ and shall continue in effect for one calendar year ending \_\_\_\_\_. Partnerships will be reviewed annually. Early termination by either party must be done in writing no less than thirty (30) days prior to termination.



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I/We have read the information on the hearing program offered through the Georgia Lions Lighthouse Foundation Hearing Aid Program and agree to the terms, provisions, and standards of practice as a participating provider.

Date: \_\_\_\_\_

Business Name: \_\_\_\_\_

DBA: \_\_\_\_\_

Please list all hearing professionals at this office so that we can track how many patients are being seen by a professional at your office. Please attach list of additional locations on a separate page. Please provide copies of licensure and insurances.

1. Hearing Professional Name and Title: \_\_\_\_\_

Email Address: \_\_\_\_\_ Professional license number: \_\_\_\_\_

2. Hearing Professional Name and Title: \_\_\_\_\_

Email Address: \_\_\_\_\_ Professional license number: \_\_\_\_\_

3. Hearing Professional Name and Title: \_\_\_\_\_

Email Address: \_\_\_\_\_ Professional license number: \_\_\_\_\_

Business Address: \_\_\_\_\_  
\_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Fax: \_\_\_\_\_

Business Website: \_\_\_\_\_

Please select the best form of communication for receiving client authorizations:

\_\_\_ Fax                      \_\_\_ Mail                      \_\_\_ Email

Contact Person for Patient Referral: \_\_\_\_\_

Is your organization tax exempt?     \_\_\_ Yes     \_\_\_ No

Employment Identification Number (EIN) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Authorized Signer*

Print Name: \_\_\_\_\_  
*Authorized Signer*

Please attach proof of malpractice insurance and copies of licensure and credentialing for all hearing professionals who will be seeing Lighthouse Foundation patients.