START HEARING

Start Hearing Owner Application

(800) 510-4194
credentialing@starthearing.com

START HEARING

Credentialing Application

The Start Hearing credentialing process exists to verify that participating Owners and Providers meet the criteria established by Start Hearing, as well as applicable government regulations and standard of accrediting agencies.

Start Hearing will conduct owner and provider initial credentialing to become part of the network, as well as a re-credentialing at least every 36 months from the date of the initial credentialing decision and/or most recent re-credentialing decision. The process is the same for both credentialing and recredentialing.

Start Hearing reviews monthly reports released by National Practitioner Databank (NPDB), State Exclusion Lists, Medicare Opt-Out, General Service Administration (GSA)/SAMs, the Office of Inspector General (OIG) and Social Security Administration/SSDM to identify any network Providers who are newly deceased, have been sanctioned or have been excluded from participating in Medicare or Medicaid.

OWNER CREDENTIALING CHECK LIST

- ◯ Owner Application and Attestation (signed by owner)
- ◯ Facility application for each dispensing location*
- ◯ Professional application for each Provider*
- ◯ Network Provider Agreement (signed by owner)
- ◯ Certificate of Professional (Malpractice) Liability Insurance
  - Required Minimum Coverage Limits - $1 million per occurrence/$3 million aggregate
- ◯ All Professionals must be covered
- ◯ Start Hearing to be named as certificate holder
- ◯ Business License (if applicable)
- ◯ Includes any city, county or state business licenses required by the city, county, or state, where the business is located, to do business.
- ◯ Current W-9
- ◯ Direct Deposit Form (if applicable)

**We will accept a roster with all required fields of the application vs. filling out an application for each servicing location and/or Provider*

Complete packet must be received within 180 days of signing the Provider Agreement.

Submission of this application and responses do not guarantee acceptance into Start Hearing network.

Start Hearing
Attn: Credentialing
6700 Washington Ave S
Eden Prairie, MN 55344

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PROFESSIONAL CREDENTIALING

We have partnered with CAQH to help with the Professional Profiles. Each Hearing Instrument Specialist and Audiologist will need to fill out the Start Hearing Professional Application and have an active CAQH Profile. Please go to www.CAQH.org and create or update your profiles and select Start Hearing as a partner.

Start Hearing Owner's Application

Primary Billing Office Information
***All payments and remits will be forwarded to this location**

☐ Initial Credentialing ☐ Renewing Credentials	STARKEY HEARING TECHNOLOGIES ACCOUNT NUMBER:	DATE:
LEGAL BUSINESS NAME (as reported to the IRS):		
DOING BUSINESS AS:		
TAX ID NUMBER:	ORGANIZATIONAL NPI:	
DO ALL LOCATIONS OPERATE UNDER SAME TIN? ☐ Yes ☐ No	IS THIS OWNER LOCATION A DISPENSING LOCATION: ☐ Yes ☐ No	
ADDRESS:		PHONE NUMBER:

CITY:	COUNTY:	STATE:	ZIP:
BUSINESS EMAIL:	Medicaid accepted: ☐ Yes ☐ No Medicare accepted: ☐ Yes ☐ No		
ENTITY TYPE: ☐ Individual ☐ Partnership ☐ Corporation ☐ Other _____			

OWNER'S NAME:	
PHONE NUMBER:	EMAIL:
BILLING CONTACT:	
PHONE NUMBER:	EMAIL:
CREDENTIALING CONTACT:	
PHONE NUMBER:	EMAIL:

Please select one (1) Primary, one (1) Secondary and as many Other as necessary

BRANDS			
STARKEY	☐ PRIMARY	☐ SECONDARY	☐ OTHER
PHONAK	☐ PRIMARY	☐ SECONDARY	☐ OTHER
RESOUND	☐ PRIMARY	☐ SECONDARY	☐ OTHER
SIGNIA	☐ PRIMARY	☐ SECONDARY	☐ OTHER
UNITRON	☐ PRIMARY	☐ SECONDARY	☐ OTHER
WIDEX	☐ PRIMARY	☐ SECONDARY	☐ OTHER
OTICON	☐ PRIMARY	☐ SECONDARY	☐ OTHER

Start Hearing Owner's Application

Business Owner Attestation and Disclosure

Confidential Professional Information

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED BY THE BUSINESS OWNER

1. Is your office ADA compliant?	☐ **Yes** ☐ **No**
2. Is your practice HIPAA compliant?	☐ **Yes** ☐ **No**
3. Does your office comply with OSHA/CDC standards and those set by the profession for barrier control techniques, sterilization, infection control, and handling of hazardous materials and/or waste?	☐ **Yes** ☐ **No**
4. Has your current business ever been disciplined, reprimanded or fined by any state licensing agency or other authorizing agency that monitors healthcare providers? *If yes, please give dates and details on separate sheet.*	☐ **Yes** ☐ **No**
5. To your knowledge, are you the subject of an investigation by any licensing board or other state or federal investigative body as of the date of this form? *If yes, please give dates and details on separate sheet.*	☐ **Yes** ☐ **No**
6. Do you maintain professional liability/malpractice (errors & omissions) coverage to at least the limits of $1 million per incident and $3 million aggregate? *If yes, please include a certificate of insurance.*	☐ **Yes** ☐ **No**
7. In the past 5 years, has your business had any malpractice or professional liability suits settled, arbitrated, litigated or mediated? *If yes, please give dates and details on separate sheet.*	☐ **Yes** ☐ **No**
8. Has your business license ever been suspended, excluded, reprimanded or debarred from, or otherwise become ineligible to participate in any state or federal government programs, Medicare and Medicaid? *If yes, please give dates and details on separate sheet.*	☐ **Yes** ☐ **No**
9. Has your business license ever experienced a voluntary or involuntary termination, limitation, reduction, loss, denial or non-renewal of a professional membership or clinical privileges? *If yes, please give dates and details on separate sheet.*	☐ **Yes** ☐ **No**
10. Have you ever been convicted of a felony? *If yes, please give dates and details on separate sheet.*	☐ **Yes** ☐ **No**
11. Have you ever been named as a defendant and/or convicted of any criminal offense related to the provision of healthcare items or services? *If yes, please give dates and details on separate sheet.*	☐ **Yes** ☐ **No**

I certify that the information provided within the Start Hearing credentialing packet is complete and accurate to the best of my knowledge. I acknowledge that my eligibility to become a participating business entity within the Start Hearing network is contingent upon the approval of the information provided within the Start Hearing credentialing packet. I agree to notify Start Hearing within ten (10) business days of any changes to the status of my business licensure and/or professional liability coverage. I certify my offices are compliant with CDC/OSHA standards for infection control and ADA accessibility standards. I understand that my application may require Start Hearing to review information related to me on file with third-party entities, including and not limited to, state licensing boards, malpractice carriers and Office of Inspector General (OIG) and Excluded Parties List System (EPLS) administered by the US Government. I consent and authorize the release of such information by any entity which requires authorization.

OWNER SIGNATURE: DATE:

PRINTED NAME:

Start Hearing Facility Application

Dispensing Facility Information

(Provide one copy of this page for each dispensing location, or submit a separate list with the required information)

BUSINESS NAME:			
ADDRESS:			
CITY:	COUNTY:	STATE:	ZIP:
PHONE:		BUSINESS EMAIL:	
INDIVIDUAL LOCATION NPI:	PRACTICE MANAGER NAME:	PRACTICE MANAGER EMAIL:	

Please list all professionals names credentialing to this office:

PROFESSIONAL:	PROFESSIONAL:
PROFESSIONAL:	PROFESSIONAL:
PROFESSIONAL:	PROFESSIONAL:
PROFESSIONAL:	PROFESSIONAL:

Office Hours:

SUNDAY:	☐ N/A	☐ BY APPOINTMENT ONLY	_____ AM	_____ PM
MONDAY:	☐ N/A	☐ BY APPOINTMENT ONLY	_____ AM	_____ PM
TUESDAY:	☐ N/A	☐ BY APPOINTMENT ONLY	_____ AM	_____ PM
WEDNESDAY:	☐ N/A	☐ BY APPOINTMENT ONLY	_____ AM	_____ PM
THURSDAY:	☐ N/A	☐ BY APPOINTMENT ONLY	_____ AM	_____ PM
FRIDAY:	☐ N/A	☐ BY APPOINTMENT ONLY	_____ AM	_____ PM
SATURDAY:	☐ N/A	☐ BY APPOINTMENT ONLY	_____ AM	_____ PM

FREE EXAM OFFERED:	☐ YES	☐ NO

SERVICE PEDIATRICS:	☐ N/A	AGES:	☐ 0-5	☐ 6-10	☐ 11-18

Professional Application

All fields in this form must be filled out for each hearing professional. Submission of this application and responses does not guarantee acceptance into network.	
DATE:	
NAME:	TITLE:
MAIDEN/FORMER/OTHER NAME(S):	
DATE OF BIRTH:	PHONE NUMBER:
INDIVIDUAL NPI NUMBER:	
*CAQH ID # *If you do not have a CAQH profile, please log onto proview.caqh.org/login to create your profile.	

LICENSE NUMBER:		STATE:	EXPIRATION DATE:
LICENSE TYPE:	☐ Au.D. ☐ HIS/HAD/HAS	CERTIFICATION TYPE:	☐ CCC-A ☐ BC-HIS

Email Address Information:

We are capturing 2 email addresses. One for all communication and one for the provider portal. Provider portal emails will be used for logins and must be unique to provider.

COMMUNICATION EMAIL:
PORTAL EMAIL:

Please list all offices to which you are credentialing:

DISPENSING LOCATION: (ADDRESS)
DISPENSING LOCATION: (ADDRESS)
DISPENSING LOCATION: (ADDRESS)
DISPENSING LOCATION: (ADDRESS)

**We will accept a roster with all required fields of the application vs. filling out an application for each servicing location and/or Provider*

New/Update Supplier Direct Deposit Form

CONTACT INFORMATION
CONTACT NAME:
EMAIL ADDRESS:
PHONE:

FINANCIAL INSTITUTION INFORMATION		
COMPANY NAME ON BANK ACCOUNT:		
ABA ROUTING NUMBER (MUST BE 9 DIGIT NUMBER):		
BANK SWIFT OR BIC NUMBER:		
BANK ACCOUNT NUMBER:		
FINANCIAL INSTITUTION NAME:		
STREET ADDRESS:		
CITY, STATE, ZIP:		
TYPE OF ACCOUNT	☐ CHECKING	☐ SAVINGS
ELECTRONIC PAYMENT NOTIFICATION EMAIL ADDRESS:		

AUTHORIZATION TO MAKE (EFT) ELECTRONIC FUND PAYMENTS

VENDOR ACKNOWLEDGES AND AGREES THAT THE TERMS AND CONDITIONS OF ALL AGREEMENTS OR PURCHASE ORDERS WITH START HEARING CONCERNING THE METHODS AND TIMING OF PAYMENTS FOR GOODS AND/OR SERVICES SHALL BE AMENDED AS PROVIDED HEREIN. VENDOR WILL NOTIFY START HEARING OF ANY CHANGES IN DEPOSITORY FINANCIAL INSTITUTION OR OTHER PAYMENT INSTRUCTIONS 15 DAYS IN ADVANCE.

NAME:	
TELEPHONE NUMBER:	
BY (AUTHORIZED SIGNATURE):	DATE:

FOR INTERNAL USE ONLY:

VENDOR NUMBER	TERMS
SUPPLIER CLASSIFICATION:	

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or ☐ C Corporation ☐ S Corporation ☐ Partnership

☐ Trust/estate ☐ Single-member LLC

Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) [a] _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

Other (see instructions) [a]

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN on page 3.*

Note: *If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter*

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person** ▶ ... **Date** ▶ ...

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.