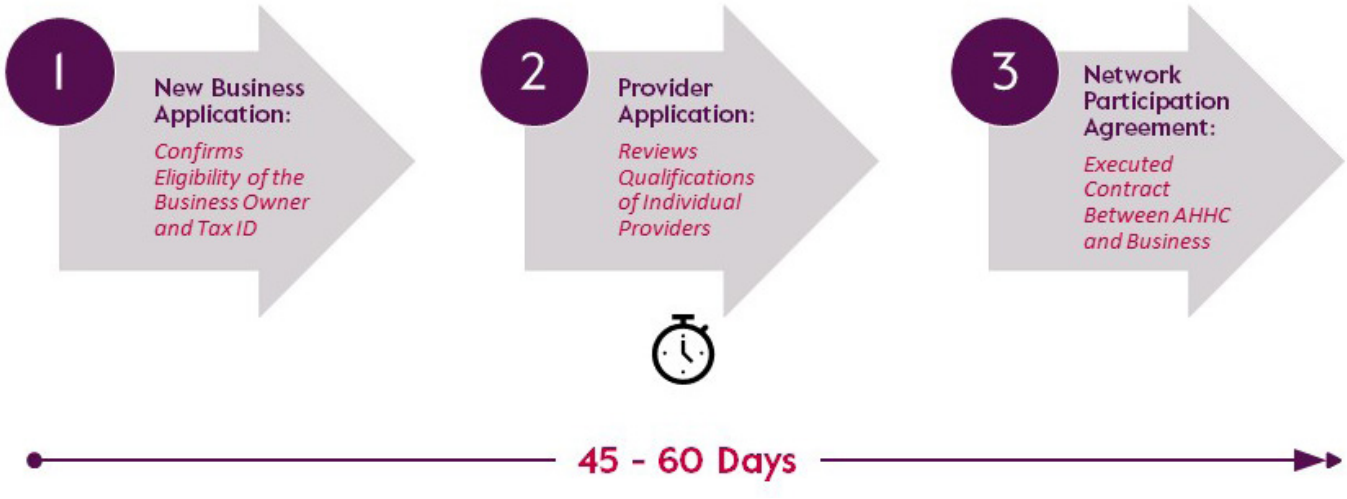
New Business Application

Working with Amplifon Hearing Health Care as a hearing care business or provider starts with the New Business Application. All businesses new to Amplifon (by Tax ID) that wish to have their hearing care providers participating in the AHHC network must submit a New Business Application form, followed by the Provider Application(s), and concluding with a Network Participation Agreement. Once your providers have completed the credentialing process, Amplifon will notify you of your Agreement effective date.



Step I: New Business Application

The New Business Application collects the legal business entity information that will be billing Amplifon and receiving payments for services. It also identifies all locations and providers that the business wishes to have covered under their Amplifon contract.

Step 2: Provider Applications

Please note that all treating providers must be individually credentialed by Amplifon. If a provider listed in the New Business Application is not currently credentialed by Amplifon, an application will be sent to them.

Step 3: Network Participation Agreement

The final step is for the Network Participation Agreement to be signed by both by parties. Amplifon will send the agreement once steps 1 and 2 have been completed. Once the contract is signed, the business will be eligible to begin seeing Amplifon referrals.

Required documents:

- Completed New Business Application
- IRS Form W-9
- Disclosure of Ownership Form

How to Submit Application:

- **Email (Preferred):** Credentialing@Amplifon.com
- **Fax:** (877) 853-3010
- **USPS:** Amplifon Hearing Health Care
  Attn: Credentialing
  150South 5th Street, Suite 2300
  Minneapolis,MN 55402

New Business Application

Business Information *(Required)*

Business Name (Legal)	
Doing Business As Name	
Organizational NPI (Type 2)	
Owner Full Name (1)	Owner Email
Owner Full Name (2)	Owner Email
Business Street Address	City, State & Zip Code
Business Phone	Business Fax
Credentialing Contact Information:	
Credentialing Contact Name	Credentialing Contact Email
Credentialing Contact Phone	Credentialing Contact Fax

Hearing Aid Manufacturers: Please list the top three manufacturers you fit in your clinics.

Clinic Locations

***All providers must be individually credentialed by AHHC. If a rostered provider is not currently credentialed by AHHC, an application will be sent to them.

Location 1				
Street Address			City, State & Zip Code	
Location Phone			Location Fax	
Location Email				
Pediatric Patients	Birth+	3+	5+	10+ 18+
Providers Practicing at Location	Provider Name (Last, First, MI)	License Number	AUD / HAD	Provider Email
**For additional providers, please attach a roster.*				

New Business Application

Location 1: Office Hours				
Day	**Start**	**AM/PM**	**End**	**AM/PM**
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				
SATURDAY				
SUNDAY				

Location 1: Accessibilities		
Does this office meet ADA accessibility requirements?		
Does this site offer handicapped access for the following:		
Building?	Parking?	Restroom?
Other handicapped access		
Text Telephony (TTY)	American Sign Language (ASL)?	
Other disability services		
Is this site accessible by public transportation?		
Bus?	Subway?	Regional Train?
Other transportation access		

Location 2				
Street Address		City, State & Zip Code		
Location Phone		Location Fax		
Location Email				
Pediatric Patients	Birth+	3+	5+	10+ 18+
Providers Practicing at Location	Provider Name (Last, First, MI)	License Number	AUD / HAD	Provider Email
**For additional providers, please attach a roster.*				

New Business Application

Location 2: Office Hours				
Day	**Start**	**AM/PM**	**End**	**AM/PM**
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				
SATURDAY				
SUNDAY				

Location 2: Accessibilities		
Does this office meet ADA accessibility requirements?		
Does this site offer handicapped access for the following:		
Building?	Parking?	Restroom?
Other handicapped access		
Text Telephony (TTY)	American Sign Language (ASL)?	
Other disability services		
Is this site accessible by public transportation?		
Bus?	Subway?	Regional Train?
Other transportation access		

If you have more than two locations,
please print additional copies as necessary and submit along with this application.

***Must be signed by the business owner

Signature _____
Signature of the person submitting this form

Name _____
Name of the person submitting this form (print)

Date of Signature _____

Disclosure of Ownership and Controlling Interest Form

Instructions: This form is to be completed by the owner(s) of record for any business that is applying for participation in the Amplifon Hearing Health Care (AHHC) network. It must be submitted to AHHC at the time of initial application, upon request by AHHC for revalidation, and within 35 days after any change to the reported information.

For definitions of key terms used in this form, please see the attached *Instructions and Glossary of Key Terms.*

I. Disclosing Entity

Legal Name of Entity		
Doing Business As (DBA)		
Federal Tax ID Number	National Provider ID (NPI)	Medicaid ID Number State of Issue _____ ◯ *Not Applicable*
Street Address		
City, State and Zip Code		

Type of Entity

◯ Sole Proprietorship ◯ Corporation ◯ Non-Profit ◯ Partnership ◯ Other (Please specify)_____

II. Ownership Interests (42 CFR §455.104)

(a) List the name, date of birth (DOB), primary address and Social Security Number (SSN) of each person having a Direct or Indirect Ownership Interest in the Disclosing Entity of 5% or greater.
(b) List the name, business address and Tax Identification Number (TIN) of each organization, corporation or entity having a Direct or Indirect Ownership Interest of 5% or greater.
(c) Attach additional sheets as necessary.

Name of Owner / Entity	DOB (mm/dd/yyyy)	Complete Address	SSN (individual) or TIN (entity)	% Ownership
		Street/PO Box City State & Zip		
		Street/PO Box City State & Zip		
		Street/PO Box City State & Zip		

Disclosure of Ownership and Controlling Interest Form

III. Controlling Interest (42 CFR §455.104)

(a) List all corporate officers, directors, Board of Directors, business partners or other individuals or entities that have a Controlling Interest in the Disclosing Entity. Include the name, date of birth (DOB) if applicable, address, Social Security Number (SSN) or Tax Identification Number (TIN) and title as applicable.

(b) Attach additional sheets as necessary.

Name of Owner / Entity	DOB *(mm/dd/yyyy)*	Complete Address	SSN (individual) or TIN (entity)	Title *(as applicable)*
		Street/PO Box City State & Zip		
		Street/PO Box City State & Zip		

IV. Ownership & Controlling Interest in Subcontractors

(a) If the Disclosing Entity from Section I has a Direct or Indirect Ownership Interest of 5% or greater in any Subcontractor, please complete the following information. If no such ownership exists, please indicate N/A and move to the next section. (42 CFR §455.104)

◯ Not Applicable (N/A)

Legal Name of Subcontractor	Subcontractor's TIN	% Interest in Subcontractor

(b) If any other individual or entity has an Ownership or Controlling Interest in the same Subcontractor, please complete the following information. ◯ Not Applicable (N/A)

Name of Individual / Entity	DOB *(mm/dd/yyyy)*	Complete Address	SSN (individual) or TIN (entity)
		Street/PO Box City/State/Zip	
		Street/PO Box City/State/Zip	

V. If any individual with an Ownership or Controlling Interest listed in Section II, III or IV above is related to another person with an Ownership or Controlling Interest listed in Section II, III or IV (such as a spouse, parent, child or sibling), please complete the following section. If no such relationship exists, please indicate N/A. Attach additional sheets as necessary. (42 CFR §455.104)

◯ Not Applicable (N/A)

Individual 1 (Name):	*Has a Relationship As:*	*To Individual 2 (Name):*

VI. If any individual with an Ownership or Controlling Interest listed in Section II or Section III above has an Ownership or Controlling Interest in any Other Disclosing Entity, please complete the following section. If no such relationship exists, please indicate N/A. Attach additional sheets as necessary. (42 CFR §455.104)

◯ Not Applicable (N/A)

Name from Section II or Section III:	*Name of Other Disclosing Entity:*	*Other Disclosing Entity's TIN:*

Disclosure of Ownership and Controlling Interest Form

VII. Business Transactions (42 CFR §455.105)

(a) Has the Disclosing Entity had any business transactions totaling more then $25,000 with a Subcontractor during the previous 12-month period, or had Significant Business Transactions with a Wholly Owned Supplier or Subcontractor during the past 5-year period?

○ Yes (Please provide information below) ○ No

Name of Subcontractor / Supplier	Address	TIN

VIII. Criminal Convictions, Sanctions, Exclusions and Terminations (42 CFR §455.106)

(a) Has any individual or entity with an Ownership or Controlling Interest identified in Sections II or III above ever:

i. Been convicted of a criminal offense related to their involvement in any program under Medicare, Medicaid or Title XX Services?

○ Yes ○ No

ii. Been excluded from participation in, or have been terminated from, any program under Medicare, Medicaid or Title XX Services?

○ Yes ○ No

(b) Has any Managing Employee or Agent ever:

i. Been convicted of a criminal offense related to their involvement in any program under Medicare, Medicaid or Title XX Services?

○ Yes ○ No

ii. Been excluded from participation in, or have been terminated from, any program under Medicare, Medicaid or Title XX Services?

○ Yes ○ No

Complete the following for any Yes answer in Section VIII: *(Attach additional sheets if necessary)*

Full Legal Name *(first, middle, last)*	Social Security Number (SSN)
Reason for Answering Yes:	
Full Legal Name *(first, middle, last)*	Social Security Number (SSN)
Reason for Answering Yes:	

Signature

By signing below, I, the owner of the Disclosing Entity or authorized officer with authority to bind the entity, certify that the information provided is true and accurate and that I will notify Amplifon of any changes to the information according to the requirements state above.

NAME (PRINT)	TITLE	PHONE NUMBER
SIGNATURE		DATE