



# 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 1: 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](mailto: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
<b>Credentialing Contact Information:</b>	
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.

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## 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.

<b>Location 1</b>					
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	
<i>*For additional providers, please attach a roster.</i>					



# New Business Application

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

<b>Location 1: Accessibilities</b>		
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		

<b>Location 2</b>					
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	
<i>*For additional providers, please attach a roster.</i>					



# New Business Application

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

<b>Location 2: Accessibilities</b>		
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 \_\_\_\_\_