State of California – Health and Human Services Agency | Department of Health Care Services

Provider Referral for Patient Enrollment

Hearing Aid Coverage for Children Program

You can send this completed form, a hearing aid prescription, or provider referral letter to us by:

1. **Online Portal:** Sign in and upload with your HACCP application at www.haccp.dhcs.ca.gov
2. **Chat:** Online at www.dhcs.ca.gov/haccp (click "Chat with us..." in the bottom corner of your screen, then select "Upload Documents")
3. **Fax:** Toll-free to 1 (833) 774-2227
4. **Mail:** Hearing Aid Coverage for Children Program
   P.O. Box 138000
   Sacramento, CA 95813

All fields marked as required must be filled

Date of Referral: _____

Patient's Information

Name (required): _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Reason for Referral (required)

☐ Hearing Aid

☐ Hearing Screening

☐ Hearing Aid Evaluation

☐ Other hearing aid-related coverage: _____

Referring Medical Provider or Hearing Professional

Individuals who can refer a patient to the HACCP may include the following:

***Audiologist** ***Otolaryngologist** ***Physician**

***Audiometrists** ***Any other trained/licensed hearing or medical professional**

Name (required): _____

Title (required): _____

Office/Center Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____