PO Box 21660
Eagan, MN 55121
Phone: 1-800-228-6080
Fax: 1-402-496-8199

HEARING INSURANCE CLAIM FORM

CLAIMANT'S PROOF OF LOSS

Insured's Name:______________________ Date of Birth:__________ Policy No.:__________

Address:____
Street City State Zip Code

Social Security No.:______________________

Telephone #:______________________

THIS SECTION MUST BE COMPLETED BY THE AUDIOLOGIST/OTOLOGIST

1. Name of Examiner:______________________ License No.:______________
2. Date of Most Recent Hearing Aid Test:______________
3. Date of Prescription for Hearing Aid:______________
4. In my professional opinion, a hearing aid ❒ is required ❒ is not required
5. Hearing Loss (%) Left Ear_______% Right Ear_______%

THIS SECTION MUST BE COMPLETED BY THE HEARING AID DEALER

1. Hearing Aid Center:______________________ License No.:______________
2. Hearing Aid Type or Model:______________________
3. Cost of Hearing Aid Appliance $______________________

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE DIAGNOSIS TO PROCEDURE BELOW)

DATE(S) OF SERVICE MM DD YY	PLACE OF SERVICE	TYPE OF SERVICE	MODIFIER	PROCEDURES, SERVICES, OR SUPPLIES CPT OR HCPCS CODE	DIAGNOSIS CODE	CHARGES	OR UNITS	LEAVE BLANK

FEDERAL TAX I.D. NUMBER SSN ❒ EIN ❒	PATIENT'S ACCOUNT NO.	ACCEPT ASSIGNMENT? (for government claims) ❒ YES ❒ NO	TOTAL CHARGES $	AMOUNT PAID $	BALANCE DUE $
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS SIGNED DATE	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # PIN # GRP #		

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above-named patient.

Subscriber Signature ______________________ Date ______________

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

over, please

Insert MI9F-4218(NC)