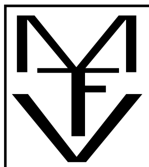
RETURN TO:

Administrative Services Only, Inc.
Department 6-H
PO Box 9005
Lynbrook, NY 11563-9005
(516) 396-5544



MOUNT VERNON FEDERATION OF TEACHERS WELFARE FUND HEARING AID CLAIM FORM

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name	Birth date	Relationship to Member Spouse ☐ Child ☐	Full Time College Student Yes ☐ No ☐	School

MEMBER/EMPLOYEE INFORMATION

Member Name		Birth date	Social Security# XXX-XX-☐☐☐☐
Street Address City	State	Zip	Telephone#
Member's School or Work Location		Work Telephone#	

SPOUSE INFORMATION

Spouse's Name (Print)	Birth date	Social Security #	Is spouse covered by another Benefits Plan? Yes ☐ No ☐
Name, Address, Telephone # of Spouses Employer			Name of Benefit Plan **IS THIS AN HMO PLAN? Yes ☐ No ☐**

ARE ANY OTHER HEARING AID BENEFITS AVAILABLE FOR THIS PATIENT? **Yes** ☐ **No** ☐

IS THIS CLAIM THE RESULT OF:
Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

THIS SECTION IS TO BE COMPLETED BY THE OTOLOGIST.

Date of most recent hearing test	Date of prescription for hearing aid	Hearing loss (%)
Hearing Aid Type or model		Left ear ____ Right ear ____

Service rendered and charges:

Hearing test and analysis	$
Hearing aid fitting	$
Hearing aid appliance	$
Total	$

Effective January 1,2014: The Fund will pay up to a maximum of $400 towards the cost of a hearing aid once every 36 consecutive months for each eligible person. Thereafter, the Fund will provide reimbursement of $100.00 for each additional hearing aid, during the same thirty-six month period. This benefit is subject to the member first submitting a claim to their basic SWSCHP plan. to the benefit This form, when completed, is to be mailed **WITH AN ORIGINAL ITEMIZED RECEIPT MARKED "PAID"** within 90 days of the date you received the services listed.

Signature of Dispenser ______________________________ **Date** ____________

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Mount Vernon Federation of Teachers Welfare Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits on services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

Signed (Patient, or Parent if Minor)______________________________ **Date** ____________