# HEARING AID CLAIM FORM

**Sheet Metal Workers' Local #83 Insurance Fund**
**900 Commerce Drive, Clifton Park NY 12065**
**518-489-1377**

## MEMBER INFORMATION:

Please type or print – Include all information indicated – submit original receipts.

Patient Name (First, Middle Initial, Last):_____

Member Name:_____

Street Address:_____

City, State, Zip:_____

Social Security Number of Member: _____ Patient Date of Birth:_____

Relationship to Member:_____ Telephone Number:_____

Do you or your spouse of other insurance? ( ) yes ( ) no (Check one)

If yes, coverage provided through:
Name of Employer:_____

Name of other coverage (Insurance Company Name):_____

Address:_____

Telephone Number:_____

Name of individual with other coverage:_____

Social Security Number: _____ Date of Birth:_____

1. Complete this form completely.
2. Attach a copy of bills for hearing aids covered under this plan. Charges should be itemized. If patient has other coverage which is also their primary coverage, also attach their explanation of benefits showing payment.
3. Bills should include the name of the patient, provider name, date of service, type of service and charges.
4. Submit the claim to the Fund Office.

**All information furnished hereon is true and correct to the best of my knowledge. I hereby authorize any provider of services to furnish the Fund with any information required to correctly process this claim.**

_____
**Member's Signature** **Date**