HEARING AID BENEFIT CLAIM

RETIREE HEALTH AND WELFARE FUND

of the

PATROLMEN'S BENEVOLENT ASSOCIATION

of the City of New York

125 Broad Street, 11th Floor

New York, New York 10004 - (212) 349-7560

CLAIM NO.

(SEE INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING FORM)

SECTION I — TO BE COMPLETED BY MEMBER

1. MEMBER'S NAME (LAST) (FIRST) (INITIAL) | 2. MEMBER'S SOCIAL SECURTIY NUMBER

3. HOME ADDRESS NO. AND STREET CITY S TATE ZIP CODE

4. PATIENT'S NAME | 5. RELATIONSHIP TO MEMBER ☐ SELF ☐ SPOUSE ☐ SON ☐ DAUGHTER | 6. PATIENT'S DATE OF BIRTH MONTH DATE YEAR

7. IF PATIENT HAS OTHER HEALTH INSURANCE COVERAGE, PLEASE GIVE: POLICY HOLDER'S NAME AND SOCIAL SECURITY NUMBER. | 8. NAME OF INSURANCE CARRIER: | 9. NAME AND ADDRESS OF EMPLOYER:

10. IS HEARINGAID REQUIRED DUE TO: WORKMEN'S COMPENSATION (L.O.D.) ☐ YES ☐ NO AUTOMOBILE ACCIDENT ☐ YES ☐ NO

11. NAME AND ADDRESS OF PRESCRIBING PHYSICIAN:

12. I CERTIFY THAT THIS CLAIM IS FOR HEARINGAID CHARGE ONLY, AND I AM ATTACHING HEREWTIH A PAID ITEMIZED BILL.

DATE _____ SIGNATURE OF MEMBER _____

SECTION II — TO BE COMPLETED BY PHYSICIAN

13. PATIENT'S NAME | 14. EXAMINED ON MONTH DATE YEAR | 15. DIAGNOSIS:

16. DEGREE OF HEARING LOSS:

RIGHT _____ LEFT _____

17. SIGNATURE OF PHYSICIAN | DATE SIGNED

FOR OFFICE USE ONLY

C.O.B. ADJUSTMENT $ _____

PBA ☐ PRIMARY ☐ SECONDARY (SEE ATTACHED)

CODED BY _____ ON _____

PRIOR CLAIM HISTORY ☐ NO ☐ YES

IF YES: PRIOR CLAIM NO. _____

DATE OF PURCHASE _____

AMOUNT PAID _____

PAID ON _____

ENTER ON SYSTEM ☐ NO MANUAL REJECTION

☐ WITH REJECTION CODE _____

CHARGE FOR HEARING AID $ _____

DATE OF PURCHASE _____

AMOUNT TO BE PAID _____

REMARKS _____

PROCESSED BY _____ DATE _____

AUDIT

RX VERIFIED WITH PHYSICIAN ON _____

COST PURCHASE VERIFIED WITH SUPPLIER ON _____

ELIG. CHECK ON SYSTEM ON _____

REMARKS _____

AUDITED BY _____ DATE _____

INSTRUCTIONS

1. THIS FORM IS TO BE USED WHEN APPLYING FOR REIMBURSEMENT UNDER THE HEARING AID BENEFIT PROGRAM. REIMBURSEMENT UNDER THIS PROGRAM CONSISTS OF AN ALLOWANCE OF UP TO $350.00 EVERY 36 MONTHS AND IS AVAILABLE TOWARDS THE INITIAL PURCHASE PRICE OF A HEARING AID FOR ALL MEMBERS OF THE RETIREE HEALTH AND WELFARE FUND AND THEIR ELIGIBLE DEPENDENTS, EFFECTIVE MARCH 1, 1982.

2. THIS BENEFIT IS NOT AVAILABLE TOWARDS THE COST OF REPAIRS, BATTERIES, ACCESSORIES, OR PROFESSIONAL EXAMINATION FEES.

3. CLAIMS NOT SUBMITTED WITHIN ONE YEAR OF THE PURCHASE DATE WILL NOT BE HONORED.

4. A PAID ITEMIZED BILL MUST ACCOMPANY THIS FORM AS EVIDENCE THAT THE PURCHASE HAS BEEN MADE.

5. SECTION 1 MUST BE COMPLETED AND SIGNED BY THE MEMBER.

6. SECTION 2 MUST BE COMPLETED AS PRESCRIBED AND SIGNED BY A PHYSICIAN (OTOLOGIST).

7. ALL CLAIMS SUBMITTED ARE SUBJECT TO REVIEW FOR DUPLICATION OF PAYMENT, I.E.: COORDINATION OF BENEFITS, WORKMEN'S COMPENSATION, NO-FAULT.

8. COMPLETED CLAIM FORMS AND ITEMIZED BILLS SHOULD BE FORWARDED TO THE P.B.A. RETIREE HEALTH AND WELFARE FUND AT THE ADDRESS SHOWN ON THE FACE OF THIS FORM.