HEARING AID BENEFIT CLAIM

Health and Welfare Fund
Police Benevolent Association of the City of New York
125 Broad Street, 11th Floor New York, NY 10004
Phone: (212) 349-7560 Fax: (212) 437-9480
www.nycpba.org

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 WHENAPPLYING 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 NOTAVAILABLE 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.