



HEARING AID BENEFIT CLAIM

RETIREE HEALTH AND WELFARE FUND
of the
PATROLMEN'S BENEVOLENT ASSOCIATION
of the City of New York
40 Fulton Street, 2nd Floor
New York, New York 10038 • (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 SECURITY NUMBER _____		
3. HOME ADDRESS _____		NO. AND STREET _____	CITY _____	STATE _____	ZIP CODE _____
4. PATIENT'S NAME _____		5. RELATIONSHIP TO MEMBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> 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 HEARING AID REQUIRED DUE TO: WORKMEN'S COMPENSATION (L.O.D.) <input type="checkbox"/> YES <input type="checkbox"/> NO AUTOMOBILE ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO					
11. NAME AND ADDRESS OF PRESCRIBING PHYSICIAN: _____					

12. I CERTIFY THAT THIS CLAIM IS FOR HEARING AID CHARGE ONLY, AND I AM ATTACHING HEREWITIH 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 \$ _____	CHARGE FOR HEARING AID \$ _____
PBA <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY (SEE ATTACHED)	DATE OF PURCHASE _____
CODED BY _____ ON _____	AMOUNT TO BE PAID _____
PRIOR CLAIM HISTORY <input type="checkbox"/> NO <input type="checkbox"/> YES	REMARKS _____
IF YES: PRIOR CLAIM NO. _____	PROCESSED BY _____ DATE _____
DATE OF PURCHASE _____	AUDIT
AMOUNT PAID _____	RX VERIFIED WITH PHYSICIAN ON _____
PAID ON _____	COST PURCHASE VERIFIED WITH SUPPLIER ON _____
ENTER ON SYSTEM <input type="checkbox"/> NO MANUAL REJECTION	ELIG. CHECK ON SYSTEM ON _____
<input type="checkbox"/> WITH REJECTION CODE _____	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.