# Hearing Aid Claim Form

**Please Attach Hearing Aid Receipt**

**PSSU Local Unit Health and Welfare Fund**
2589 Interstate Drive
Harrisburg, Pennsylvania 17110
Local (717) 526-4856 Toll Free (888) 243-1524

| **To Be Completed by Employee** | | |
|---|---|---|
| Employee's Full Name (Last, First, Mid) | Employee Social Security No. | Daytime Phone Number ( ) |
| Street Address | City | State Zip |

| **Patient Information - If Claim Is for Your Dependent** | | | | |
|---|---|---|---|---|
| Patient's Full Name (Last, First) | Social Security No. | Sex ❑M ❑F | Patient's Date of Birth | Relationship to Employee ❑Self ❑Spouse ❑Daughter ❑Son ❑Stepchild |

Is patient a full-time student age 19 to 23? ❑Yes ❑No If yes, expected date of graduation _____/_____/_____
Is patient covered by any other benefit plan, group plan, school plan, Medicare or government plan? ❑Yes ❑No
Name and social security number of the person covered by other insurance plan_____
Name of other group and group no._____
Name of other group insurance plan and phone no._____

**Certificate of Medical Clearance - To Be Completed by M.D. or D.O.**

a. Date of otologic examination of the ear _____/_____/_____
b. Medical Diagnosis_____
Physician's Name_____Signature_____Date_____
Physician's Address_____
Physician's Phone Number (Include area code) _____

**To Be Completed by Licensed Individual Giving Examination**

a. Date of audiometric examination _____/_____/_____
b. Date of hearing aid evaluation _____/_____/_____
c. Date hearing aid was ordered _____/ _____ / _____
d. Indicate which ear is being fitted ❑ Left Ear ❑ Right Ear
Name_____
Address_____
Phone Number (Include area code)_____
Signature_____Date_____

**Employee Authorization to Release Information:**

I hereby authorize the physician or organization furnishing services or supplies to provide the FUND with the patient's information that is requested within this application. I certify that the information given by me in support of this application is true and correct. **I hereby agree to reimburse the Fund for any overpayment by the Fund to me or on my behalf and regardless of whether such payment is made to me directly or to some third party on my behalf. I recognize and acknowledge that if I provide false or misleading information to the Fund or any third party dealing with the Fund on my behalf, that such action by me constitutes a violation of applicable federal and state law and may subject me to possible criminal prosecution and appropriate civil liability.**

**Employee Signature**_____**Date**_____

*This Claim Form must be completed in its entirety before consideration can be granted for payment to the participant by the **PSSU Local Unit Health and Welfare Fund.***