

HEARING AID COVERAGE

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN AND RETURNED TO EMPLOYEE)

Any person who, knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

Physician's or Supplier's Statement (Payment can be made directly to employee.)

1. Patient's Name		2. Patient's Date of Birth					
3. Date of Illness (First Symptom) or Injury	4. Date the Patient First Consulted You for This Condition.		5. Has Patient Ever Had Same or Similar Symptoms?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Name & Address of Facility Where Services were Rendered (if other than home or office)							
7. If Hearing Test Was Administered, Give Date:		8. Date Hearing Aid Dispensed		9. Do You Consider the Injury or Sickness Work Related?			
10. If Patient Has Additional Coverage, Please Identify:							
11. Type of Hearing Aid Dispensed: (a) Design (check one): <input type="checkbox"/> In-the-ear <input type="checkbox"/> Behind-the-ear <input type="checkbox"/> On-the-body <input type="checkbox"/> Eyeglasses <input type="checkbox"/> Other (specify below) _____							
(b) Ear fitted: <input type="checkbox"/> Left <input type="checkbox"/> Right							
12A. Place of Service*	12B. Fully Describe Procedures, Medical Services or Supplies Furnished For Each Date Given:		12C. ICD-9 Code	12D. Charges		12D. Date of Service	13. Amount Paid
	CPT-4 Code	(Explain Unusual Services or Circumstances)					
				\$			\$ _____
				\$			14. Balance Due
				\$			
				\$			\$ _____
			15. Total Charge	\$			
16. Physician's or Supplier's Name					Address		17. Telephone No. ()
18. Signature of Physician or Supplier					Date		▶ Required By Federal Law

Place of Service Codes

(H) - Hospital (inpatient)
(X) - Hospital (outpatient)

(O) - Office
(E) - Elsewhere

(M) - Home
(D) - Home Health Care

(K) - Hospice Care
(C) - Extended Care Facility

(A) - Ambulatory Surgicenter