PLEASE RETURN TO:
Self-Insured Dental Services
Dept. 27-H
P.O. Box 9005
Lynbrook, NY 11563
(516) 396-5544/(718) 204-7172
www.asonet.com

NEW ROCHELLE FEDERATION OF UNITED SCHOOL EMPLOYEES WELFARE FUND

HEARING AID BENEFIT CLAIM FORM

MEMBER INFORMATION

Member's Name		Birth Date ___/___/___	Social Security Number	
Address	City		State	Zip Code
Home Phone				

THIS SECTION MUST BE COMPLETED BY THE AUDIOLOGIST/ORTOLOGIST

1. Name of Examiner:	License No.:
2. Date of Most Recent Hearing Aid Test	___/___/___
3. Date of Prescription for Hearing Aid	___/___/___
4. In my professional opinion, a hearing aid	☐ is required ☐ is not required
5. Hearing Loss (%)	Left Ear _____% Right Ear %_____

THIS SECTION MUST BE COMPLETED BY THE HEARING AID DEALER

1. Hearing Aid Center:	License No.:
2. Hearing Aid Type or Model	
3. Cost of Hearing Aid Appliance	$

INSTRUCTIONS

1. **The Plan will reimburse the member only up to a maximum of $1000 per hearing aid appliance per ear during a 36 month period.**
2. **Hearing aid appliances must be prescribed by a duly licensed physician, audiologist or otologist.**
3. **Exams covered annually - Maximum allowance $45.00**
4. **Mail completed forms WITH AN ORIGINAL OR COPY OF AN ITEMIZED RECEIPT MARKED "PAID" within 1 year of the date you received the services listed.**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the NEW ROCHELLE FEDERATION OF UNITED SCHOOL EMPLOYEES or its designated agent to release all information with respect to myself which may have a bearing on the benefits payable under this or any other plan providing benefits on services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

Member Signature _____ **Date** _____

You may photocopy this claim form.