PLEASE RETURN TO:
Administrative Services Only Inc,.
PO Box 9005
Lynbrook, NY 11563
(516) 396-5500
(800) 537-1238 (Toll Free Outside NY State)
(718) 204 –7172

LEVITTOWN UNITED TEACHERS

HEARING AID BENEFIT CLAIM FORM
EFFECTIVE 3/1/2022

PATIENT INFORMATION (REQUIRED ON ALL CLAIMS)

Patient' Name	Birth Date	Relationship to Member
	____/____/____	☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child
Is This Claim a Result of an Accident or Injury? ☐ YES ☐ NO If Yes, Please Describe	**Are Any Other Hearing Aid Benefits Available For This Patient?** ☐ YES ☐ NO **If yes, you must attach proof of payment from all other benefit plans covering this service**	

MEMBER INFORMATION

Member's Name	Birth Date	Social Security Number	
	____/____/____		
Address	**City**	**State**	**Zip Code**
Marital Status ☐ Single ☐ Married ☐ Divorced/Legally Separated ☐ Widowed		**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-Effective 3/1/2022

1. **Eligible Members and their dependents (as defined the Summary Plan Description) are covered for hearing aid devices once per 48 months up to a maximum of $2,000. Dependents under age 12 will be reimbursed once in a 24 month period if hearing loss change warrants new devices.**
2. **Obtain a referral for a hearing aid from your physician or audiologist and have him fill out the section above.**
3. **Complete the member and patient section of this claim form and sign below.**
4. **This form, when completed, is to be mailed WITH AN ORIGINAL OR COPY OF AN ITEMIZED RECEIPT MARKED "PAID" with payment vouchers from all other benefit programs covering this service within 12 months of the date you received the Hearing Aid Appliance.**

AUTHORIZATION TO RELEASE INFORMATION: Authorization must be signed, or payment will not be made.
I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Levittown United Teachers Benefits Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or 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 complete, true, and correct**. Authorization must be signed, or payment will not be made.**

Member's Signature_____ **Date** _____