Hearing Aid Claim Form

PEBTF Hearing Aid Program
Claims Dept-Hearing Aids
1200 Route 46 West
Clifton NJ 07013-2440

Please Attach Hearing Aid Receipt

Phone: (800) 672-7723

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, Mid)	Social Security No.	Sex	Patient's Date of Birth	Relationship to Employee
		❑ M ❑ F		❑ Self ❑ Spouse ❑ Daughter ❑ Son ❑ Stepchild

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 ❑ CROS ❑ Binaural

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 PEBTF Hearing Aid Program 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 PEBTF Hearing Aid Program. ***Please note that benefit information and the instructions for the completion of this form are printed on the reverse side.***

HEARING AID PROGRAM INFORMATION

PEBTF Hearing Aid Program Toll Free (800) 672-7723

The Hearing Aid Program offers you or your eligible dependents the opportunity to apply for hearing aid reimbursement. Please refer to your **"PEBTF Summary Plan Description"** in order to understand the main features of your coverage and for questions related to eligibility information and continuing coverage under COBRA.

- **Hearing Aid Benefit** *This benefit is limited to one hearing aid per 36-month period for each ear*. Eligibility for a replacement aid or aids becomes effective 36 months from the *order date* of the previous aid obtained under the program. Binaural aids or CROS aids will also be considered with medical authorization.
- **Reimbursement Allowance under the Program** If it is medically substantiated that an aid is required, the program will allow reimbursement to you for one of the stated maximums listed below:
  - For a monaural aid (one) in either ear, the program will allow up to a maximum of $900
  - For binaural aids (an aid in each ear), the program will allow up to a maximum of $1,800
  - For a CROS aid, the program will allow up to a maximum of $2,400

  Reimbursement Allowance for the Hearing Aid Evaluation Test The hearing aid evaluation test is performed by a physician/audiologist or licensed dealer/fitter and may determine which make and model will best compensate for the loss of hearing acuity. *Inclusive with the maximums stated above, the program will allow for the cost of the test as long as the cost of the hearing aid(s) does not exceed the maximums stated above. If the cost of the hearing aid(s) exceeds the maximum, the program will not pay for the cost of the hearing aid evaluation test.*

  Under no circumstances is payment considered for a hearing aid unless the audiometric examination and the hearing aid evaluation test are performed within six months of the most recent otologic examination of the ear by licensed practitioners.
- **Hearing Aid Claim Form** The **"Hearing Aid Claim Form"** must be completed in its entirety and returned to the PEBTF Hearing Aid Program office. Send the Hearing Aid Claim Form along with an itemized receipt reflecting the purchase of the hearing aid(s) and/or the cost of the hearing aid evaluation test. *After these procedures have been followed, the PEBTF Hearing Aid Program will reimburse the employee for the charge up to the program's stated maximums.* **Under no circumstances is payment made directly to a medical doctor, audiologist, laboratory or authorized dealer/fitter.**

- **Exclusions/Limitations**
  - ★ Hearing aid evaluation tests, or hearing aids for which there is no physician's certificate of medical clearance (a medical waiver is accepted for replacement aids obtained under other programs), audiometric examination or hearing aid application.
  - ★ Those drugs or other medications prescribed in conjunction with the hearing aid. The prescriptions (legend drugs only) should be submitted separately under your prescription drug program.
  - ★ Any service which is already covered under your medical surgical plan, worker's compensation, or any other plan or organization.
  - ★ Reimbursement for the cost of the hearing aid evaluation test or the purchase of the hearing aid after termination of benefit coverage with the Fund.
  - ★ Replacement parts or batteries for hearing aids
  - ★ Any charges for the completion of insurance forms.
  - ★ Replacement or repair of hearing aids that have been lost or broken unless, at the time of replacement, the covered person is again eligible (i.e., 36 months [1,095 days] have transpired since services were last covered).
  - ★ Coverage for audiometric examinations that are billed separately and are not included in the total dealer charge.
  - ★ Charges for hearing aid evaluation tests and/or hearing aids will not be paid if the date of service is beyond six months of the most recent medical examination of the ear and if tests have not been performed by licensed practitioners.
  - ★ Charges for hearing aid evaluation tests and/or hearing aids which are not necessary according to professionally accepted standards of practice or which are not recommended or approved by the physician.
  - ★ Charges for hearing aid evaluation tests and hearing aids that do not meet professionally accepted standards of practice, including charges for any such services or supplies that are experimental in nature.

CLAIMS FOR REIMBURSEMENT UNDER THE HEARING AID PLAN MUST BE SUBMITTED (POSTMARKED) TO THE PEBTF HEARING AID PROGRAM WITHIN ONE YEAR OF THE DATE OF SERVICE.