AFSCME CARE Plan

Return This Form to:

OHIO AFSCME CARE PLAN
1603 East 27th Street
Cleveland, Ohio 44114
Phone: (216) 781-6420

STATEMENT OF CLAIM
HEARING AID BENEFIT

☐ Check Box for Address Change

14

PROOF OF CLAIM must be submitted not later than 90 days following the first day of illness or accident.

FOR ALL CLAIMS

NAME OF EMPLOYEE | MALE ☐ FEMALE ☐ | DATE OF BIRTH DAY MO. YEAR | EMPLOYED BY

EMPLOYEE'S ADDRESS | STREET & NO. | CITY | ZIP CODE

FOR DEPENDENT CLAIMS

NAME OF DEPENDENT | MARRIED ☐ SINGLE ☐ | RELATIONSHIP TO EMPLOYEE | DATE OF BIRTH DAY MO. YEAR

IS DEPENDENT EMPLOYED? | NAME AND ADDRESS OF DEPENDENT'S EMPLOYER

IF DEPENDENT IS A FULL-TIME STUDENT, 19 YEARS OF AGE OR OLDER, GIVE NAME AND ADDRESS OF SCHOOL:

Name of School | # Units Taken | City | State | Zip Code

FOR ALL CLAIMS

ARE YOU OR YOUR DEPENDENT INSURED FOR HEARING AID BENEFITS PROVIDED UNDER ANY OTHER EMPLOYER, UNION, ASSOCIATION, BLUE CROSS, BLUE SHIELD, OR OTHER GROUP INSURANCE PLAN? YES ☐ NO ☐

IF YES, INSERT POLICY NUMBER, NAME AND ADDRESS OF INSURANCE COMPANY OR ORGANIZATION PROVIDING SUCH BENEFITS OR SERVICES.

Policy No. | Cert. No. | Name and Address

I HAVE REVIEWED THE FOREGOING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED PHYSICIAN OF BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

SIGNED (PATIENT OR PARENT IF MINOR) | DATE | SIGNED (INSURED PERSON) | S.S.# | DATE

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN (Attach itemized bill from supplier)

PATIENT'S NAME (First Name, Middle Initial Last Name) | PATIENT'S DATE OF BIRTH | WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT? YES ☐ NO ☐

DATE FIRST CONSULTED YOU FOR THIS CONDITION | DATE MEASURED | IS THIS INITIAL PLACEMENT? YES ☐ NO ☐

IS THIS CLAIM FOR REPLACEMENT OF A LOST, STOLEN OR BROKEN APPLIANCE? YES ☐ NO ☐ | IF NO, REASON FOR REPLACEMENT | DATE OF PRIOR PLACEMENT

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE

1.
2.
3.
4.

A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY:) (Explain unusual services or circumstances)	D DIAGNOSIS CODE	E CHARGES	F
		HEARING TEST AND ANALYSIS/HEARING AID FITTING/HEARING AID APPLIANCE/AUDIOLOGIST SHOW BRAND NAME, MODEL, RESPONSE, GAIN, POWER OUTPUT, TYPE EARMOLD			

I HEREBY CONFIRM THE FACT THAT THE ABOVE MENTIONED PATIENT DOES REQUIRE THE USE OF A HEARING AID.
SIGNATURE OF PHYSICIAN

SIGNED | DATE

YOUR SOCIAL SECURITY NUMBER

YOUR PATIENT'S ACCOUNT NUMBER

YOUR EMPLOYER I.D. NUMBER

TOTAL CHARGE | AMOUNT PAID | BALANCE DUE

PHYSICIAN'S NAME, ADDRESS, ZIP CODE AND PHONE NUMBER.

I.D. NUMBER

*PLACE OR SERVICE CODES
1—(IH)—INPATIENT HOSPITAL
2—(OH)—OUTPATIENT HOSPITAL
3—(O)—DOCTOR'S OFFICE
4—(H)—PATIENT'S HOME
5—DAY CARE FACILITY (PSY)
6—NIGHT CARE FACILITY (PSY)
7—(NH)—NURSING HOME
8—(SNF)—SKILLED NURSING FACILITY
9—AMBULANCE
0—(OL)—OTHER LOCATIONS
A—(IL)—INDEPENDENT LABORATORY
B—OTHER MEDICAL/SURGICAL FACILITY