

# CSEA Employee Benefit Fund Hearing Aid Claim Form



Form must be completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached.

## MAJOR PLAN FEATURES

- This benefit reimburses an allowance toward the cost of a hearing aid, including charges for its fitting upon the recommendation of a physician.
- Reimbursement is processed up to the maximum benefit allowed per the collective bargaining agreement, per eligible patient.
- Hearing aid repairs, batteries, and other non-durable equipment are not reimbursable.

## INSTRUCTIONS

- Submit your completed claim form with an itemized receipt of payment and an Explanation of Benefits (EOB) from your health insurance.
- All claims must be submitted no later than December 31st of the following calendar year.
- Submit for this benefit only if it has been negotiated for you under your collective bargaining agreement.
- Reimbursement allowances will not exceed the amount paid out for services.

## TO BE COMPLETED BY MEMBER (PLEASE PRINT)

Member's Name \_\_\_\_\_ EBF ID # \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Daytime Phone # \_\_\_\_\_ Email \_\_\_\_\_

## Claim Information (PLEASE CHECK ONE BOX)

Patient Name \_\_\_\_\_ Relationship \_\_\_\_\_

### In what ear does the patient wear the hearing aid?

Left ear only

Right ear only

Both ears

Date of Purchase \_\_\_\_\_

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please allow up to 6 weeks for processing.*

## MAIL COMPLETED CLAIM TO

CSEA Employee Benefit Fund  
PO Box 516  
Latham, NY 12110-0516

**CLAIMS ARE NOT ACCEPTED BY FAX OR EMAIL**