

hearing care

group claim form

Group Claims Adjusters
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PART 1 – TO BE COMPLETED BY EMPLOYEE

1. Patient's full name (first, middle initial, last)		2. Patient birthdate (MM/DD/YY)		3. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other		4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
5. Employee's full name (first, middle initial, last)		6. Employee's identification number		Employee's birthdate (MM/DD/YY)			
7. Employee's mailing address (Street address or P.O. Box, City, State, ZIP)		8. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER Is patient a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, name and address of school					
9. Employer (company) name and address Email address		10. Group number		Division number		Certificate number	
11. Other employee/subscriber name		Employee/subscriber ID number		Date of birth (MM/DD/YY)		Relationship to patient	
12. I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of treatment. I certify these statements to be true and complete to the best of my knowledge. <input checked="" type="checkbox"/> Signature (patient, or parent if minor) _____ Date _____		13. I hereby authorize payment directly to the below named provider of group insurance benefits otherwise payable to me. <input checked="" type="checkbox"/> Signature (insured person) _____ Date _____					

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PART 2 – TO BE COMPLETED BY ATTENDING HEARING CARE PROVIDER.

14. Hearing care provider name and mailing address		For Yes answers to questions 16-19, enter a brief description and date.					
Specialty		16. Is treatment result of occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Phone number		17. Is treatment result of auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Fax number		18. Other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Email		19. If hearing aid, is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for replacement, and date of prior replacement					
15. Federal tax ID number <input type="checkbox"/> SSN <input type="checkbox"/> TIN		NPI (National Provider Identifier)		20. This is a (please check one): <input type="checkbox"/> Statement of actual services <input type="checkbox"/> Pretreatment estimate			
License / ID #							

21. EXAMINATION AND TREATMENT RECORD Please include date of service, description of services, procedure code and fee.							
Date service performed (MM/DD/YY)	Description of services	CPT/HCPCS procedure code	Diagnosis code	Left ear	Right ear	Fee	
22. Remarks							23. Total \$

24. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes. <input checked="" type="checkbox"/> Signature (Provider) _____ Date _____		25. Address where treatment was performed
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TO BE COMPLETED AFTER TRIAL PERIOD

<p>26. Provider measurement outcome Test utilized: <input type="checkbox"/> PROB MIC <input type="checkbox"/> COSI <input type="checkbox"/> APHAB <input type="checkbox"/> HINT <input type="checkbox"/> other</p> <p>Signature below from both Hearing Aid Provider and Patient are required upon completion of patient TRIAL period to validate patient's satisfaction and decision to keep the hearing aid(s). Please fax this signed authorization and agreement form back to First Ameritas.</p> <p>Fax Number: 402.467.7336</p>	<p>27. Hearing aid information</p> <p>Patient was fit with hearing aids on Date: _____</p> <p>Hearing aids serial numbers Right: _____</p> <p>Hearing aids serial numbers Left: _____</p>
<p>28. Signatures</p> <p><input type="checkbox"/> Patient has finalized hearing aid purchase.</p> <p><input type="checkbox"/> Patient has returned hearing aid(s). New recommendation will be made. NEW AUTHORIZATION FORM REQUIRED PRIOR TO ORDERING.</p>	<p>X _____ Signature (Patient) Date</p> <p>X _____ Signature (Provider) Date</p>

tips

how to speed claims processing

part 1 – employee

Missing or incomplete information will slow down claims processing. To avoid this, please be sure to include:

#2 Patient birthdate

Helps identify an insured and determine dependent eligibility.

#6 Employee’s identification number

This is the most important identifier for the plan member.

#8 Student status

Because this information often changes, it is required on every claim for dependents age 19 years and older.

part 2

To help expedite the claims process, please be sure to include:

#15 National Provider Identifier

There are two types of NPI. Type 1 is for individual providers who operate independently. Type 2 is for health care providers such as group practices or corporations. Type 2 organization providers may want their individual provider employees to have Type 1 NPIs to distinguish them individually.

#19 Hearing Aid - Initial Replacement?

Required for hearing aids. If not initial replacement, prior placement date is needed.

#20 Statement of actual services, or Pretreatment estimate

Appropriate box should be marked to ensure correct handling.

#21 Supporting Documentation

Narratives may be submitted. Documents should be dated and legible. Please indicate both, left or right. All supporting documentation should be current within one year. Procedure codes listed are based on CPT and/or HCPCS.

pretreatment estimate of benefits

We recommend a pretreatment estimate of benefits when a plan member considers the services to be expensive. A pretreatment estimate lets both the member and hearing care provider know in advance how much insurance will pay. If hearing care coverage terminates for any reason during treatment, only procedures performed before coverage ended will be eligible for payment.

For full information regarding coverage, plan members may refer to their insurance plan booklet.

website

Visit our website for electronic forms and contact information. Please note, the free software Adobe Reader® (available through the internet) is needed to view and print the electronic forms.