HEARING

Social Security or AID No. _____

GSA-ILA EMPLOYERS WELFARE FUND
HEARING MEDICAL CARE CLAIM FORM

PHYSICIAN, AUDIOLOGIST, OR SUPPLIER

PHYSICIAN, AUDIOLOGIST, OR SUPPLIER: IT IS YOUR RESPONSIBILITY TO ENSURE THIS FORM IS COMPLETE AND TO SIGN BELOW.

SECTION A. PATIENT AND EMPLOYEE (SUBSCRIBER) INFORMATION

1. Patient's Full Name (Please Print)	**5.** Patient's Relation to Insured Self ❑ Spouse ❑ Child ❑ Other ❑	**7.** Employee's Full Name (Please Print)
2. Patient's Address (Street, City, State, Zip)	**6.** Was Condition Related to: **A.** On the job injury: ❑ Yes ❑ No Explain: _____	**8.** Employee's Address (Street, City, State, Zip)
3. Patient's Birthdate (Mo/Da/Yr)	**B.** Accidental Injury: ❑ Yes ❑ No Explain: _____	**9.** Employee's Birthdate (Mo/Da/Yr) **10.** Employee's Social Security or AID Number
4. Patient's Sex: ❑ Male ❑ Female	**C.** Auto Accident: ❑ Yes ❑ No Explain: _____	**11.** Employee's Daytime Telephone Number

12. Other Health Care Coverage – Enter name of policyholder, Plan name, address, and policy or medical assistance number:

13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. *I Authorize the Release of any Medical Information Necessary to Process this Claim.* *SIGNED* _____ *DATE* _____	**14.** I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW. THIS AUTHORIZATION IS INVALID UNLESS TAXPAYER IDENTIFICATION NUMBER (TIN) OF PHYSICIAN OR SUPPLIER IS PROVIDED BELOW. *SIGNED* _____ *DATE* _____

SECTION B. EXAMINING PHYSICIAN, AUDIOLOGIST, OR SUPPLIER INFORMATION

15. Physician, Audiologist, or Supplier's Full Name (Please Print):	Physician, Audiologist, or Supplier's Address: (Street, City, State, Zip)	
16. Telephone Number:	**17.** You are required under authority of law to enter the Taxpayer Identification Number (TIN) or the Physician or Supplier's Social Security Number to be used for 1099 reporting purposes.	**18.** Title: ❑ Physician ❑ Audiologist ❑ Supplier

19. What was the sickness or injury?	**22.** If patient required <u>new</u> hearing aids, <u>repair</u> of hearing aids, or <u>replacement</u> of hearing aids, please indicate the date the hearing aids were: ❑ Ordered _____ ❑ Repaired _____ ❑ Delivered _____
20. On what date did it begin?	
21. If hearing aids were <u>replaced</u>, please indicate the reason they were replaced (i.e., lost, stolen, broken, etc…):	

23. If patient required an <u>examination</u>, please provide the dates of the last three (3) examinations (Mo/Da/Yr) and explain the purpose of each:

Date: _____; Purpose_____;
Date: _____; Purpose_____;
Date: _____; Purpose_____;

24. Hearing care services or supplies provided:	Left Ear	Right Ear	Description of Product, including brand name:
❑ Examination	❑	❑	
❑ New Hearing Aid(s)	❑	❑	
❑ Repair of Hearing Aid(s)	❑	❑	
❑ Replacement Hearing Aid(s)	❑	❑	

Dates of Service (Mo/Da/Yr) From	To	Procedure Code(s)	Place of Service Code(s)	Diagnosis Code(s)	Charges	Please briefly describe the diagnosis or nature of sickness, disease, or bodily injury:	Fully Describe the Procedures, Medical Services, or Supplies Furnished for Each Date Given:
					$		
					$		
					$		

<u>Payments and Total Charges</u>: **25.** Total Charge: $ **26.** Paid by Insured: $ **27.** Balance Due: $

COUNTY OF CHATHAM)
STATE OF GEORGIA)

ACKNOWLEDGMENT

The undersigned hereby acknowledges that he/she understands that it is a crime to knowingly make false statements and representations of fact, or knowingly conceal, cover-up, or fail to disclose any required fact, in any document required by or is necessary to verify, explain, clarify or check for accuracy and completeness of any report required by the Employee Retirement Income Security Act of 1974 ("ERISA") and that any false statement or representation made in reporting may subject him/her to prosecution under 18 U.S.C. §1027, the penalty for which is a fine of $10,000.00 or imprisonment of five (5) years or both. By signing below, the undersigned further hereby acknowledges and agrees to periodic audits in reference to said claims by GSA-ILA Employers Welfare Fund auditors. I further hereby certify that the procedures or supplies as indicated above have been completed or delivered and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures or supplies.

(Name of Physician) _____ Date: _____ Physician or Supplier signs here **X** _____

Please file claim and related documents with:
<u>Mailing Address</u>
ILA EMPLOYERS WELFARE FUND
POST OFFICE BOX 1280
SAVANNAH, GEORGIA 31402-1280

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