

hearing care

group claim form

Group Claim Office
 P.O. Box 82520 / Lincoln, NE 68501-2520
 toll free 877.359.8346
 fax 402.467.7336
 web ameritasgroup.com



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) Email address	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	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. X 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. X Signature (insured person) _____ Date _____		

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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. 16. Is treatment result of occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Specialty	17. Is treatment result of auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone number 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. X Signature (Provider) _____ Date _____	25. Address where treatment was performed

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 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><input checked="" type="checkbox"/> _____ Signature (Patient) _____ Date _____</p> <p><input checked="" type="checkbox"/> _____ 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.