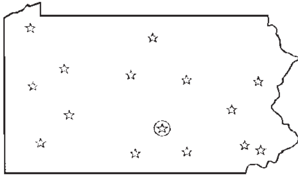

PENNSYLVANIA FACULTY
HEALTH AND WELFARE FUND

P.O. Box 60430
Harrisburg, Pennsylvania 17106-0430

Telephone: (717) 233-4776

HEARING EXAMINATION AND HEARING AID APPLIANCE BENEFIT CLAIM FORM

Answer Each Item In Order To Qualify For This Benefit
Please Print Clearly

Member's Name: ______________________ Member's Date of Birth: __________

Home Address: ______________________ Member's Telephone #: __________

______________________ Patient's Date of Birth: __________

Patient's Name: ______________________

Member's Signature: ______________________

IMPORTANT: Return this form to the Fund Office with an itemized statement(s) attached.

PHYSICIAN OR AUDIOMETRIC SPECIALIST MUST COMPLETE THE FOLLOWING:

Provider's Name: ______________________ Specialty: __________

Office Address: ______________________ Telephone: __________

____

Services Rendered: ______________________

Based upon the above hearing examination and tests, I (Please check)

______ do not recommend that this patient obtain a hearing aid.

______ recommend that this patient be fitted with the following:

Brand Name & Model No. ______________________

Frequency response & Battery Power ______________________

Other Specification (describe) ______________________

I personally examined and rendered service for this patient.

Provider's Signature ______________________ Date of Service __________