HealthSelect of Texas

Policy Number: 744260
Customer Service # 1-866-336-9371

Hearing Aid Battery Claim Form

UnitedHealthcare®
SAN ANTONIO SERVICE CENTER
PO BOX 740809
ATLANTA , GA 30374-0809

PLEASE SEND HEARING AID CLAIM FORM TO SPECIAL ADDRESS LISTED ABOVE

A. MEMBER / EMPLOYEE INFORMATION

Subscriber ID:		Phone #: ( )	
Last Name:	First Name:	MI:	Date of Birth / /
Home Address:		New Address? (check box) Yes ☐ No ☐	
City:	State:		Zip Code:

B. PATIENT INFORMATION

Last Name:	First Name:	MI:	Date of Birth / /
Home Address:			
City:	State:		Zip Code:
Sex (circle one): M F	Relationship to Member:		

C. OTHER INSURANCE

Is the patient covered by another insurance plan? (check box) Yes ☐ No ☐ If yes, please complete the following:		
Name of person carrying other insurance:		Date of Birth / /
Social Security #:	Name of Other Insurance Carrier:	
Policy Number:	Employer Name:	

D. DIAGNOSIS AND HCPCS CODES

Diagnosis: Please check one of the following:

	Code	Description
____	389.9	Unspecified hearing loss

Please check the item(s) for which you are requesting reimbursement:

Check Box	Date (MM/DD/YYYY)	Place of Service	Code	Description	Total Cost	Quantity(#of batteries)
		OF	V5266	Battery for use in hearing device		

E. PHYSICIAN'S NAME: Pharmacy Tax Identification Number 0-069000008-00001

F. REMINDERS

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALITIES.

- Be sure to include a legible copy of your pharmacy receipt (REQUIRED)
- Clip, do not staple, all receipts to the completed form and mail them to UnitedHealthcare at the address above
- Make sure all bills indicate date of service and cost (refer to Section D above)
- Submit all claims to UnitedHealthcare in a timely manner
- Be sure to notify your employer of all address changes
- Please include your Subscriber Id on all documents