**United Food & Commercial Workers Unions and Food Employers Benefit Fund**
6425 Katella Avenue, Cypress, CA 90630-5238
P.O. Box 6010, Cypress, CA 90630-0010
714-220-2297 • 562-408-2715 • 877-284-2320
www.scufcwfunds.com

# Statement Of Claim For Hearing Aids

| This Claim is for: ☐ Self ☐ Child ☐ Spouse | Patient's Last Name | Patient's First Name | ☐ Male ☐ Female |
|---|---|---|---|

| Mailing Address *(if different from Participant)* Street: | City | State | ZIP Code | Date of Birth (mm/dd/yy) |
|---|---|---|---|---|

## Participant Information

*Supply all information requested below whether the claim is for yourself or a dependent. Please print clearly*

| Last Name | First Name | Mid. Initial | Social Security or Family ID Number |
|---|---|---|---|

| Mailing Address Street: | City | State | ZIP Code | Date of Birth (mm/dd/yy) |
|---|---|---|---|---|

| Home Phone ( ) / Work Phone ( ) | Email Address | ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed |
|---|---|---|---|

| Employer | Employer's Address Street: | City | State | ZIP Code |
|---|---|---|---|---|

## Other Coverage

*Supply all information requested below whether the claim is for yourself or a dependent.*

| Spouse/Domestic Partner's Last Name | First Name | Mid. Initial | Social Security or Family ID Number |
|---|---|---|---|

| Mobile Phone ( ) / Work Phone ( ) | Date of Birth (mm/dd/yy) | ☐ Male ☐ Female | Is your Spouse/Domestic Partner employed? ☐ Yes ☐ No | Your Spouse/Domestic Partner's employer, ☐ does ☐ does not offer health care coverage. |
|---|---|---|---|---|

| Spouse/Domestic Partner's Employer | Employer's Address Street: | City | State | ZIP Code |
|---|---|---|---|---|

| Is the patient for whom this claim is filed covered by your spouse/domestic partner's or any other group plan? ☐ Yes ☐ No | Is the patient for whom this claim is filed under your spouse/domestic partner's or any other vision coverage? ☐ Yes ☐ No |
|---|---|

| Name any individuals covering patient under other group plans: | Relationship to You | Name other dependents covered under this plan: |
|---|---|---|

| Other Insurance Mailing Address Street: | City | State | ZIP Code | Other Insurance Phone ( ) |
|---|---|---|---|---|

| Is the patient covered by? ☐ Medicare ☐ A plan provided by a federal, state or other government agency? | Name of agency |
|---|---|

## Assignment of Benefits

*Sign this section if you want benefits paid directly to the provider.*

I hereby authorize payments directly to the provider named in the back of this form of the benefits otherwise payable to me under the terms and conditions of the Benefit Fund. I understand I am financially responsible to the provider for charges not covered by this assignment.

Participant's Signature _____ Date _____

## Certification

*You must sign this section in order to have your claim processed.*

I hereby certify the statements hereon and those attached are true and correct to the best of my knowledge and I authorize any physician, surgeon, practitioner or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or other institution or organization, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other claims. A Photostat of this authorization shall be as valid as the original. I understand that it is fraudulent to fill out this form with information I know to be false or to omit important facts, and that criminal or and/or civil penalties can result from such acts.

Participant's Signature _____ Date _____

# Attending Physician's/ Hearing Aid Dispenser's Statement

| Patient's Name | Participant's Name |
|---|---|
| | |

Diagnosis and complications, if any: _____

When did claimant first consult you for this condition? _____

## Hearing Aid *If a hearing aid was dispensed, discribe the appliance, including name and model number.*

| Date prescribed | Charge for examination $ | Charge for hearing aid $ |
|---|---|---|
| | | |

## Other Coverage *If a hearing aid was dispensed, supply the information below.*

| To your knowledge, does the patient have other health insurance or health plan coverage? ☐ Yes ☐ No | Please indicate other coverage |
|---|---|
| | |

## Provider Information *The following information must be provided in order to process your claim.*

| Physician's Last Name | First Name | Mid. Initial | Tax I.D. Number | |
|---|---|---|---|---|
| | | | | |
| **Physician's Mailing Address** Street: | City | State | ZIP Code | Physician's Phone ( ) |
| | | | | |
| Degree | Specialty | | Date | |
| | | | | |
| Hearing Aid Dispenser's Last Name | First Name | Mid. Initial | Tax I.D. Number | |
| | | | | |
| **Hearing Aid Dispenser's Mailing Address** Street: | City | State | ZIP Code | H.A. Dispenser's Phone ( ) |
| | | | | |

## Requirement For Hearing Aid Documentation

If this claim is for a hearing aid sold by a person other than the attending physician, a vendor's statement must accompany this form. The statement should identify the appliance by description, manufacturer and model number.

## Provier's Certification

I hereby authorize the United Food & Commercial Workers Unions and Food Employers Benefit Fund to examine the patient's medical records upon presentation of authorization signed by the patient or qualified person.

_____

Attending Physician's Signature Date

*Please Return This Form To* - Benefit Fund Office, Medical Claims Department, PO Box 6010, Cypress, CA 90630-0010