MEMBER REIMBURSEMENT FORM (Hearing Aids):

Reason for Reimbursement:

□ **Hearing Aids**

Member Information:

Member ID number (on the front of your Medicare Advantage ID card): _____

Member name: _____

Member sex: □ Male □ Female

Member date of birth: Month _____Day_____Year_____

Member Daytime phone number: _____

I am the □ Member

I authorize release of all information pertaining to this claim to the plan administrator or its designees. Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Member Signature:_____Date:_____

MEDICAL CLAIM INFORMATION (Complete applicable information.)

Date of service:_____

Amount requested: $:_____

Description of service:_____Left Ear _____ Right Ear _____

Provider's name:_____

Provider's phone:_____

Provider's address:_____

Include copy of provider's bill

Please mail this claim to:
Ochsner Health Plan Claims
P.O. Box 4318
Scranton, PA 18505