PSC-CUNY WELFARE FUND

61Broadway, 15th Floor, New York, NY 10006
212-354-5230 Fax (212) 354-5363

BE CERTAIN TO INCLUDE INVOICE!

Hearing Aid Reimbursement Form

File within 90 Days of Service

Member

Last Name _____ **First Name** _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Social Security Number _____

Employer (College) _____

Member Status: ☐ Full Time ☐ Adjunct ☐ Retired ☐ COBRA ☐ Survivor ☐ On Leave

Patient

Relationship to Member ☐ Self ☐ Spouse / Domestic Partner ☐ Dependent Child

Complete the following only if the Patient is <u>not</u> the Member :

Name of Patient _____

Other Hearing Aid Coverage **Name of Employer or Union** _____ **Contact** _____

To Be Completed by Provider

Name _____ **License No.** _____ **Lic. Type** ____

Street Address _____

City _____ **State** _____ **Zip Code** _____

<u>Type of Service</u>	<u>Charges</u>		<u>Charges</u>
Testing	☐ _____	Hearing Aid	☐ _____
Fitting	☐ _____		
		Total Charges	_____

Signature of Member _____ **Date** _____

Signature of Provider _____ **Date** _____

OFFICE USE ONLY : Check # ____ Check Date _____ Amt. _____ *Approved* _____