PSC CUNY Welfare Fund
61 Broadway, 15th Floor, New York, NY 10006
Phone: 212-354-5230 *Fax: 212-354-5363*

BE CERTAIN TO ENCLOSE INVOICE!

Hearing Aid Reimbursement Form

Please File within 90 Days of Service

Member

Last Name _____ **First Name** _____

Street Address _____

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

Social Security Number _____

Employer (College) _____

Member Status: ☐ Active ☐ Retired ☐ COBRA ☐ Survivor ☐ Leave of Absence

Patient

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

Complete the following only if the Patient is not 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** _____

Type of Service	Charges		Charges
☐ Testing		☐ Hearing Aid	
☐ Fitting			
		Total Charges	$

Signature of Member _____ **Date** _____

Signature of Provider _____ **Date** _____

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