Boston Teachers Union
Health and Welfare Fund
180 Mt. Vernon Street
Boston, MA 02125
(617) 288 -0500

HEARING AID BENEFIT CLAIM FORM

Note: This benefit does not include payment for any portion of the charge made by the hospital for the required Audiology Test. Terms of the benefit are attached.

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TO BE COMPLETED BY COVERED TEACHER

Covered Teacher's Name: _____City ID #_____
Covered Teacher's Address: _____
Patient's Name: _____
Relationship to Member: _____DOB_____
Signature of Covered Teacher: _____

I am covered by health benefits through **(circle one):**

I. Blue Cross Blue Shield
2. HMO Blue /Blue Choice
3. Harvard Pilgrim Health Care
4. Tufts Affiliated Health Plan
5. Neighborhood Health Plan
6. Other (list)

Signature of Covered Teacher: _____

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TO BE COMPLETED BY APPROVED HOSPITAL FACILITY
(See instruction sheet for definition)

Patient's Name: _____Date of Audiology Test: _____
Name of physician recommending Audiology Test: _____
Is a hearing aid recommended for **(circle**) Right Ear_ Left Ear__ Both Ears___
If so, list name and address of supplier recommended by you.

_____
Name of Hospital: _____
Authorized Signature_____

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TO BE COMPLETED BY RECOMMENDED SUPPLIER

INSTRUCTIONS: THE FUND MAKES PAYMENT DIRECTLY TO THE SUPPLIER.
Complete this portion of the form and return with bill for hearing aid to the Boston Teachers Union Health and Welfare Fund at the address shown above.
Call (617) 288-0500 to confirm that the Teacher is still eligible for this coverage, and the amount of the purchase price up to $5,000 ($2,500 per ear) will be covered.
Name and address of supplier: _____
Cost of hearing aid: _____ **(Attach bill)** Date of Purchase: _____

Teacher Fund Office Use Only:
Check #____Date Issued: _____ Amount Paid by Fund: ____Approved By_____

This benefit does not pay for repairs nor does it pay for replacement of a lost or damaged hearing aid, so recipients may want to insure their hearing aid against loss or damage.