

Form Instructions**Please type or print clearly****Section 1**

This section is for the patient's personal information. It is not the policy holder's information.

For example, if a parent is the policy holder, but the child is the person who received services, then the child's information should be listed in Section 1. All lines are required in Sections 1, 2, and 3.

Section 2

"Legal name" means the first and last name of the audiologist or specialist who dispensed the hearing aids. "Practice name" is the business name.

You can obtain the National Provider ID # (NPI) from your provider's office.

Section 3

"CPT Code" means Current Procedural Terminology. It means the 5 digit code for the type of hearing test received, or the type of hearing aids purchased. This number would be provided by your audiologist.

Section 4

Assignment of Benefits to Provider: If the patient checks this box, the insurance funds will be disbursed to the Provider's office not to the patient. We require a W9 form from the office for payment this way. Most patients will not want to check off this box, especially if they already paid in full.

Claim form must be signed.

Digital signatures or typed names are accepted, if filling out the form on a computer, tablet, or phone.

If form is signed by a 3rd party, we require a copy of their durable power of attorney paperwork which names this signer as the patient's attorney-in-fact. An Assignment of Representative form may be submitted in place of the power of attorney.

What else is on the form?

On the top of the Member Reimbursement Form, you will find a list of documents required to accompany your Member Reimbursement Form.

The bottom of the form lists the 3 methods you can use to send the complete documents to TruHearing.

The following documents must be submitted for reimbursement within 365 days from date of service:

- 1. This complete form, signed and dated
- 2. Copy of itemized receipt
- 3. Copy of completed and signed purchase agreement

Section 1

Member information

Legal Name: _____
Date of Birth: _____
Health Plan Member ID#: _____
Address: _____
City/State/Zip: _____
Phone: _____

Section 2

Provider information

Legal Name: _____
Practice Name: _____
National Provider ID#: _____
Address: _____
City/State/Zip: _____
Phone: _____

Section 3

Diagnosis & procedure codes

Diagnoses: _____
CPT Codes: _____

Section 4

Cost to the patient

Date of Service: _____

Cost of Hearing Aids: _____

Cost of Hearing Exam: _____

Cost of Batteries: _____

Assignment of Benefits to Provider (Provider must submit W9 to TruHearing with claim form)

Section 5

Authorization & signature

Patient's Signature: _____

Today's Date: _____

Please send all requested documents to TruHearing via any of these methods:

By mail

Attention: Claims
TruHearing
5889 Greenwood Plaza Blvd, Suite 300
Greenwood Village, CO 80111

By email

Claims@TruHearing.com

By fax

1-303-889-5137

Questions?

Please call: 1-855-312-2545