[redacted]

MTA Metro-North Rail Road Group Benefits Program

Statement of Claim for Hearing Aid

Employee's Statement

Answer all questions below.
Omitted information will cause delays.

1. Employee's Name (print) First Middle Last	2. Social Security Number	3. Date of Birth	4. ☐ Male ☐ Female
5. Present Address: Street City State Zip Code	6. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	7. Telephone No. ( ) Area Code	

Patient Information - Complete this section only if different from employee.

8. Patient's Name (print) First Middle Last	9. Social Security Number	10. If Age 19 or over ☐ Student ☐ Full Time ☐ Part Time ☐ Disabled If Student, Name of School & City
11. Date of Birth / 12. Relationship / 13. ☐ Male ☐ Female / 14. Marital Status ☐ Single ☐ Married		

Family Employment - Complete this section only if other members, including dependent minors, are employed.

15. Name of Family Member	16. Social Security Number	17. Relationship	18. Age	19. Employer's Telephone No. ( ) Area Code	20. Spouse's Date of birth Month _____ Day _____
21. Employer's Name (print)	22. Employer's Address - Street City State Zip Code				

Accident Information - Complete this section only if claim is result of accidental injury or occupational sickness.

23. Date of Accident	24. Time of Accident _____ ☐ A.M. ☐ P.M.	25. Where Did the Accident Occur? (City/State)	26. Auto Accident ☐ Yes ☐ No Name of Insurer _____
27. Describe Accident or Occupational Sickness:			28. Did the Accident/Sickness Happen at Work? ☐ Yes ☐ No

Other Coverage Information - This section must always be completed.

29. Are any benefits or services provided under another group insurance plan or any prepayment plan, or pursuant to any law (Federal, State, or Local) on account of the treatment reported on this claim? ☐ Yes ☐ No If "Yes," answer (30) or (31) whichever applies, and (32).	32. Give Name and Address of Other Company or Organization Providing Benefits or Services. Name Address City State Zip Code
30. Other Insurance Coverage is: ☐ Group ☐ Individual ☐ Other (specify) ▶	
31. Name or Type of Law is (e.g., Medicaid, Champus, No-Fault)	Please Indicate Plan Identification No. or Blue Cross/Blue Shield Group No.(s). ▶

Medical Authorization

33. Insured employee must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to this claim and the expenses reported. I certify that the information I furnish in support of this claim is true and correct. The Insurance Company may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.	34. Signed (Employee) Date Signed (Dependent patient, not minor) Date

Payment of benefits to be made directly to employee.

Mail Completed Form To ▶

MTA BSC
333 W. 34th Street 9th Floor
New York, NY 10001-2402

Employer: _____

Group No. _____ Branch _____ Subdivision _____

GH 24-HA-38888 (2/95)

JY2146.SCRE(01/02)

HEARING AID COVERAGE

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN AND RETURNED TO EMPLOYEE)

Any person who, knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

Physician's or Supplier's Statement (Payment can be made directly to employee.)

1. Patient's Name		2. Patient's Date of Birth
3. Date of Illness (First Symptom) or Injury	4. Date the Patient First Consulted You for This Condition.	5. Has Patient Ever Had Same or Similar Symptoms? ☐ Yes ☐ No
6. Name & Address of Facility Where Services were Rendered (if other than home or office)		
7. If Hearing Test Was Administered, Give Date:	8. Date Hearing Aid Dispensed	9. Do You Consider the Injury or Sickness Work Related? ☐ Yes ☐ No
10. If Patient Has Additional Coverage, Please Identify:		

11. Type of Hearing Aid Dispensed:

(a) Design (check one): ☐ In-the-ear ☐ Behind-the-ear ☐ On-the-body ☐ Eyeglasses ☐ Other (specify below)

_____

(b) Ear fitted: ☐ Left ☐ Right

12A. Place of Service*	12B. Fully Describe Procedures, Medical Services or Supplies Furnished For Each Date Given: CPT-4 Code	(Explain Unusual Services or Circumstances)	12C. ICD-9 Code	12D. Charges	12D. Date of Service	13. Amount Paid
				$		$
				$		14. Balance Due
				$		
				$		$
			15. Total Charge	$		

16. Physician's or Supplier's Name	Address	17. Telephone No. ( )
18. Signature of Physician or Supplier	Date	Required By Federal Law

Place of Service Codes

(H) - Hospital (inpatient) (O) - Office (M) - Home (K) - Hospice Care (A) - Ambulatory Surgicenter

(X) - Hospital (outpatient) (E) - Elsewhere (D) - Home Health Care (C) - Extended Care Facility