



Western Division
P.O. Box 956
Toledo, OH 43695-0956

HEARING CLAIM FORM

PART I PATIENT AND CERTIFICATE HOLDER INFORMATION		(Please Print or Type)
1. Certificate Holder's Name _____ Address _____ City _____ State _____ Zip _____ Phone (_____) _____	6. Patient's date of birth Age _____ / / 7. Patient's relation to Certificate Holder self (male) self (female) husband 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> wife son daughter 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> other male dependent other female dependent 7 <input type="checkbox"/> 8 <input type="checkbox"/>	10. ** IMPORTANT ** If the patient is covered by any other group or non-group health insurance, including Medical Mutual of Ohio™, please complete this section. Name of other employer _____ Address of other employer _____ Name of other person employed _____ Birthdate of other person employed _____ Relationship to patient _____ Other health care plan _____ If the patient is a child and parent's are divorced, please answer the following: a. Which parent has custody of the patient? _____ b. Is there a court decree that states which parent is responsible for medical bills? ___ yes ___ no If yes, please attach a copy of the court decree.
2. Patient (first name, middle initial, last name) _____ 3. Certificate Holder's ID number: _____ Medical Mutual of Ohio™ Plan code: _____ <small>(Numbers can be found on Certificate Holder's ID card)</small>	<p>If this arrow appears on your ID card, copy the information as it appears.</p>	8. Is patient full-time student 19 years of age or older? <input type="checkbox"/> yes <input type="checkbox"/> no Name of school: _____ 9. Was condition related to: A. Employment <input type="checkbox"/> yes <input type="checkbox"/> no B. Accident <input type="checkbox"/> yes <input type="checkbox"/> no Date of Onset: _____
4. Group name: _____ 5. Group number: _____	5a. I authorize release of any information relative to this claim to be used by Medical Mutual of Ohio™ or a review agency with which it has contracted solely for the purposes of determining reimbursement. _____ DATE: _____ <small>(Signature of Certificate Holder or Spouse)</small>	

NOTE: For this claim to be considered for payment, it must be accompanied by a "Certificate of Need" from a physician stating that a hearing aid would compensate for the loss of hearing.

PART II PHYSICIAN OR PROVIDER INFORMATION		(To be completed by physician or provider only)					
13. Date symptom first appeared: _____	14. Date patient first consulted you for this condition: _____	15. Has patient ever had symptoms? <input type="checkbox"/> yes <input type="checkbox"/> no	16. Referring physician: _____				
17. Name and address of facility where service was rendered (other than home or office): _____		18. Is patient total disabled? <input type="checkbox"/> yes <input type="checkbox"/> no	Dates of total disability: From _____ To _____				
19. A medical examination verifying hearing loss was performed on _____ by _____							
20. A Date of service	B Place of service (see back)	C Type of service	D Description: Explain unusual services or circumstances related to procedures, medical services or supplies furnished for each date given	E Diagnosis code ICD-9-CM	F Charges	G Days or Units	H (Internal use only)
		Audiometric Exam					
		Hearing Aid Evaluation					
		Hearing Aid Acquisition Cost	Type _____ Model _____				
		Hearing Aid Dispensing Fee					
		Conformity Evaluation					
		Sales Tax					
Internal use only				21. Total charges		To make payment, your taxpayer identification number must be in Block 23.	
22. Patient account number		23. Identification number or (taxpayer ID)					
I certify that these services were performed by me or in my presence under my supervision				24. Physician/provider name _____ Address _____ City _____ State _____ Zip _____ Signature _____			

FOR THE CERTIFICATE HOLDER

1. Use this form for all your hearing claims. Use a separate form for each patient and each physician.
2. Complete all items on Part 1 of the form for both the patient and the Certificate Holder. If any information is missing a delay in processing will result. Make sure you sign the form in Block #5A to authorize release of information.
3. After completion of Part 1 give the form to your physician.

FOR THE PHYSICIAN OR PROVIDER

1. Use a separate claim form for each patient and each provider rendering service. If you are a member of a group practice, the services of all physicians in your group can be reported on one claim if the first 11 digits of their ID number is the same.
2. Review the top of the form to make sure the employee has provided all information, especially Coordination of Benefits (Block 10) and a signature (Block 5A). Missing information will cause a delay in processing.
3. Complete Part II with all information pertinent to the patient's treatment. Be sure to indicate the type of procedure coding used.
4. Be sure to use your taxpayer ID number in Block 23.

PLACE OF SERVICE CODES

1-(IH)	- INPATIENT HOSPITAL
2-(OH)	- OUTPATIENT HOSPITAL
3-(O)	- DOCTOR'S OFFICE
4-(H)	- PATIENT'S HOME
5-	- DAY CARE FACILITY (PSY)
6-	- NIGHT CARE FACILITY (PSY)
7-(NH)	- NURSING HOME
8-(SNF)	- SKILLED NURSING FACILITY
9-	- AMBULANCE
0-(OL)	- OTHER LOCATIONS
A-(IL)	- INDEPENDENT LABORATORY
B-	- OTHER MEDICAL/SURGICAL FACILITY
C-	- DENTAL OFFICE
D-	- INPATIENT DRUG FACILITY
E-	- OUTPATIENT DRUG FACILITY
F-	- INPATIENT PSYCHIATRIC
G-	- HEMOPHILIA TREATMENT CENTER
H-	- HOSPICE FACILITY

ATTENTION CERTIFICATE HOLDERS:

Use this form to file for hearing expenses. These charges may be accumulated until you reach your deductible amount or filed separately. The physician does not need to complete Part II. A separate form must be completed for each patient.

Each statement must be itemized and contain the following information:

Name of patient
Date of each service
Charge for each service
Type of treatment