



PENNSYLVANIA FACULTY

HEALTH AND WELFARE FUND

P.O. Box 60430
Harrisburg, Pennsylvania 17106-0430

Telephone: (717) 233-4776

HEARING EXAMINATION AND HEARING AID APPLIANCE BENEFIT CLAIM FORM

Answer Each Item In Order To Qualify For This Benefit

Please Print Clearly

Member's Name: _____ Member's Date of Birth: _____

Home Address: _____ Member's Telephone #: _____

_____ Patient's Date of Birth: _____

Patient's Name: _____

Member's Signature: _____

IMPORTANT: Return this form to the Fund Office with an itemized statement(s) attached.

PHYSICIAN OR AUDIOMETRIC SPECIALIST MUST COMPLETE THE FOLLOWING:

Provider's Name: _____ Specialty: _____

Office Address: _____ Telephone: _____

Services Rendered: _____

Based upon the above hearing examination and tests, I (Please check)

_____ do not recommend that this patient obtain a hearing aid.

_____ recommend that this patient be fitted with the following:

Brand Name & Model No. _____

Frequency response & Battery Power _____

Other Specification (describe) _____

I personally examined and rendered service for this patient.

Provider's Signature _____ Date of Service _____