1. PROVIDER NAME

2. MAILING ADDRESS

RECEIVED CASE NO.

HIGHMARK. Delaware

P.O. Box 1991
Wilmington, DE 19899

HEARING AID CLAIM FORM

3. CITY	STATE	4. ZIP CODE

5. Is claim a result of on-the-job safety requirement or injury?	YES	NO	If yes, enter description and date

6. PROVIDER SOC. SEC. OR TIN	7. ID NUMBER	8. PROVIDER PHONE NO.

9. Is treatment a result of auto or other accident?			

10. PATIENT'S NAME - First, Middle, Last

11. Are any services covered by other insurance?			

12. RELATIONSHIP TO SUBSCRIBER				13. SEX	14. PATIENT'S BIRTH DATE		
1-Self	2-Spouse	3-Child	4-Other	❑ Male ❑ Female	Mo.	DAY	Yr.

15. NAME AND ADDRESS OF INSURANCE COMPANY IN ITEM 11.

16. SUBSCRIBER'S ID NUMBER

17. ANY OTHER FAMILY MEMBER'S EMPLOYED?
Employee's Name Social Security Number

18. SUBSCRIBER'S NAME - First, Middle, Last

19. NAME AND ADDRESS OF EMPLOYER IN ITEM 17.

20. MAILING ADDRESS

21. PLACE OF TREATMENT
Office Outpatient Other

22. CITY	STATE	23. ZIP CODE

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24. DATE OF SVC. Mo., Day, Yr.	DESCRIP. OF SERVICE	PROCEDURE CODE	DIAGNOSIS CODE	TOTAL CHARGE	COVERED CHARGE	BCBS ALLOWANCE	COMMENTS
	Audiometric Exam						
	Hearing Aid Eval.						
	Conformity Eval.						
	Hearing Aid (Acq.)						
	Hearing Aid (Disp.)						
	TOTAL CHARGES						

25. NAME OF REFERRING PHYSICIAN — DATE REFERRED

26. NAME OF REFERRING AUDIOLOGIST — DATE REFERRED

27. HEARING AID MANUFACTURER

28. NAME OR MODEL NUMBER OF HEARING AID

29. I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

Provider Signature: **Date:**

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a claim containing false, incomplete or misleading information may be guilty of a felony.

FOR HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE USE ONLY

Type Transaction	Group Number	Type Contract	Type Provider	Payee	Provider Specialty	COB	Hospital Code	Place of Treatment	Processor Number	Date Processed

022—Claim	L—In-Par	2—In-state	54—Optician/Hearing Aid Dealer	1—Inpatient	
023—Refusal	P—In Non-Par	3—Out-of-State	04—Otolaryngologist	2—Outpatient	
024—Correction	R—Out-Par	4—Subscriber	64—Audiologist	3—Office	
025—Manual	X—Out Non-Par				

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