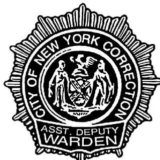
RETURN TO:
ADMINISTRATIVE SERVICES ONLY, INC.
Department 66-H
PO Box 9005
Lynbrook, NY 11563

(516) 396-5500 / (718) 204-7172



ASSISTANT DEPUTY WARDENS DEPUTY WARDENS ASSOCIATION

☐ ACTIVE ☐ RETIREE

HEARING AID CLAIM FORM

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name:	Birth Date:	Social Security #: (Last 4 digits) XXX-XX-______	Relationship to Member: Self ☐ Spouse ☐ Child ☐

MEMBER/EMPLOYEE INFORMATION

Member Name:		Birth Date:		Social Security #: (Last 4 digits) XXX-XX-______
Street Address:	City:	State:	Zip Code:	Telephone #:
Email: (Non-DOC)		Work Location:		Work Telephone #:

SPOUSE INFORMATION

Spouse's Name: (Print)	Birth Date:	Social Security #: (Last 4 digits) XXX-XX-______	Is spouse covered by another Benefits Plan? YES ☐ NO ☐
Name, Address, Telephone # of Spouse's Employer: **(MUST BE COMPLETED OR CLAIM WILL BE RETURNED)**		Name of Benefit Plan:	
ARE ANY OTHER HEARING AID BENEFITS AVAILABLE FOR THIS PATIENT? YES ☐ NO ☐ **If YES, you MUST attach proof of payment from all other benefit plans covering this service.**		**IS THIS AN HMO PLAN?** YES ☐ NO ☐	

AUDIOLOGIST / ORTOLOGIST INFORMATION

Provider's Name (Print)		License #:	Telephone #
Address	City	State	Zip Code
Name of Hospital where confined:			Telephone #
Address	City	State	Zip Code
Is this claim the result of: Accident or Injury? YES ☐ NO ☐		Occupational Injury? YES ☐ NO ☐	

CERTIFICATE OF CONFINEMENT

Check One (✓)	Completed by:	☐ HOSPITAL	☐ ATTENDING PHYSICIAN	
Patient Name: (Print)	Age:	Date Admitted:	Date Still Confined:	Date Discharged:
Diagnosis from Records:				
Date of any previous confinement: From:	To:	Is condition due to any occupational cause: YES ☐ NO ☐		
Completed By: (Name)		Title:	Date Information was taken from records:	
Address:		Signature:		
City:	State:	Zip Code:	Date:	

PLEASE ATTACH:

1. A COPY OF THE HOSPITAL BILL WITH PATIENT NAME AND DATE OF SERVICE.
2. EXPLANATION OF BENEFITS FROM BASE MEDICAL PLAN.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Assistant Deputy Wardens Deputy Wardens Association or its designated agent to release a// information with respect to myself or any of my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct. **Authorization must be signed or payment will not be made.**

Signed (Patient, or Parent if Minor): ____________________ **DATE:** __________

ASSIGNMENT OF BENEFITS:

I hereby authorize payment of the benefits (otherwise payable to me). I understand I am financially responsible for charges not covered by this authorization.

Signed (Member): ____________________ **DATE:** __________

FOR OFFICE USE ONLY Check #: ________

VERIFICATION SIGNATURE: __________ DATE ___/___/___ Check Issued Date: ___/___/___