SHEET METAL WORKERS' LOCAL 73 WELFARE FUND
4530 ROOSEVELT ROAD
HILLSIDE, ILLINOIS 60162
PHONE (708) 449-7373

CLAIM FOR HEARING AID BENEFITS

IMPORTANT

INSTRUCTIONS FOR FILING CLAIMS:
1. COMPLETE THE TOP PORTION OF THIS PAGE.
2. HAVE YOUR DOCTOR OR AUDIOLOGIST COMPLETE BOTTOM PORTION.
3. **ATTACH PAID BILL FOR HEARING AID DEVICE(S).**

1. MEMBER'S SOCIAL SECURITY NO. _____

2. MEMBER'S NAME _____
(FIRST) (INITIAL) (LAST)
ADDRESS _____
(STREET NUMBER) (CITY) (STATE) (ZIP CODE)
HOME PHONE NO. _____

3. PATIENT'S NAME _____
(FIRST) (INITIAL) (LAST)
PATIENT IS: ☐ MYSELF ☐ SPOUSE ☐ CHILD PATIENT IS: ☐ MALE ☐ FEMALE
PATIENT DATE OF BIRTH_____ PATIENT'S SOC.SEC.NO. _____

4. _____ _____
MEMBER'S SIGNATURE DATE

THIS PORTION IS TO BE COMPLETED BY A DOCTOR OR BY AN AUDIOLOGIST WHO IS CERTIFIED BY THE AMERICAN SPEECH-LANGUAGE HEARING ASSOCIATION.

1. PATIENT'S NAME_____ AGE_____
(FIRST) (INITIAL) (LAST)
2. DATE OF MOST RECENT HEARING EXAMINATION _____
3. TEST RESULTS:
AIR CONDUCTION: _____
BONE CONDUCTION: _____
SPEECH AUDIOMETRIC: _____
1. S.R.T.: _____ 2. P.B.- MAX.: _____
IMPEDANCE RESULTS: _____
4. NAME OF DOCTOR OR AUDIOLOGIST _____
ADDRESS_____
SIGNATURE_____ DATE_____20____