Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

P.O. Box 4604 • 800.258.9732
51 Goffstown Road • 603.669.4771
Manchester, NH 03108 • f 603.666.4477

Hearing Reimbursement

The subscriber, covered spouse and/or adult dependent(s) over the age of 19 are eligible for the Hearing Aid benefit. The benefit will reimburse 75% of the total cost up to a max of $3,000/per person once every 3 years.

SECTION 1: MEMBER INFORMATION

Member's Full Name	Date of Birth / /	SSN (last 4 digits)
Mailing Address	City	State	Zip Code
Marital Status	Employer
Primary Phone ( )	E-mail Address

SECTION 2: CLAIMANT INFORMATION ❒ Check box if Claimant is the member and skip to Section 3

Claimant's Full Name	SSN (last 4 digits)
Mailing Address (if different)	City	State	Zip Code
Prime Phone Number ( )	E-mail Address

SECTION 3: ITEMIZED CLAIM DETAIL (include a receipt for each date of service)

Provider / Facility Name	Daytime Phone Number ( )
Mailing Address	City	State	Zip Code
Was care coordinated by EPIC Hearing? ❒ Yes ❒ No	Was an EPIC Hearing provider used? ❒ Yes ❒ No

SECTION 4: PROVIDER INFORMATION

Date of Service	Description of Service	Provider Charge

****Attach paid receipt from provider showing all care and charges for each individual service. Failure to provide an adequate account of services and charges will cause a delay in processing or denial of claim****

SECTION 5: CERTIFICATION & AUTHORIZATION

I certify that the information provided on this form is complete and accurate. I authorize the provider to release any information to Allegiant Care that would be necessary to process this claim. I understand the reimbursement will be made directly to the member listed in Section 1.

Claimant Signature: _____ **Date:** _____

Return the completed form to the mailing address noted above.
You may also fax it directly to 603-792-7214 or email to claims@myallegiantcare.com.
Retain a copy of this form for your records.