# HEARING AID REIMBURSEMENT FORM

Please complete all information requested. An incomplete form may either delay your reimbursement or may be returned for additional information. Reimbursement is not guaranteed. Claims will be reviewed and are subject to limitations, exclusions and other provisions of the Plan benefit. **Please note that all reimbursement checks will be made out to the Subscriber for the cost of the device/service minus PPO deductible and co-insurance.**

Date Submitted: _____Member Name: _____

Date of Birth: _____ Member ID: _____

Phone Number: _____ Social Security Number: _____

Date(s) of Service_____ Reimbursement Amount_____

Provider/Facility/Retailer Name:

_____

Provider/Facility/Retailer Address:

_____

**Benefit- Hearing Aids and Cochlear Implant:**

- For members who are 20 years of age and younger, 1 hearing aid device per ear may be reimbursed every **5 years** from the month it is dispensed.
- For members who are 21 years of age and older and has at least a 35dB hearing loss in both ears, 1 hearing aid device may be reimbursed every **5 years** from the month it is dispensed.
  For more information on this benefit please reference the TPA UMC Plan Document at www.preferredadmin.net

**Method of Check Reimbursement**

**All Checks will be mailed to the address on file with Preferred Administrators**
**If your address has changed, please reach out to your HR Department to update your address **

**Signature: _____ Date: _____**

Mail or fax form to: Preferred Administrators
P.O. Box 971370
El Paso, TX 79997-1370
Fax# 915-225-1174

If you have any questions, please contact Preferred Administrators at 915-532-3778 ext. 1529.

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***For Administrative Use Only***

Signature: _____ Date: _____

Approved: ☐ Denied: ☐ Approved Reimbursement Amount: $ _____

Notes:

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