



**MEMBER REIMBURSEMENT FORM (Ochsner Hearing Solutions):**

**Reason for Reimbursement:**

**Hearing Aids**

Member Information:

Member ID number (on the front of your Medicare Advantage ID card): \_\_\_\_\_

Member name: \_\_\_\_\_

Member sex:  Male  Female

Member date of birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Member Daytime phone number: \_\_\_\_\_

I am the  Member

I authorize release of all information pertaining to this claim to the plan administrator or its designees. Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL CLAIM INFORMATION (Complete applicable information.)**

Date of service: \_\_\_\_\_

Amount requested: \$: \_\_\_\_\_

Description of service: \_\_\_\_\_ Left Ear \_\_\_\_\_ Right Ear \_\_\_\_\_

Provider's name: \_\_\_\_\_

Provider's phone: \_\_\_\_\_

Provider's address: \_\_\_\_\_

**Include copy of provider's bill**

**Please mail this claim to:  
Ochsner Health Plan Claims  
P.O. Box 4318  
Scranton, PA 18505**