ManhattanLife™

MAIL TO:
MANHATTANLIFE
CLAIMS DEPARTMENT
P.O. BOX 925309
HOUSTON, TX 77292-2728
FAX: 713-583-0677

DENTAL, VISION, HEARING CLAIM FORM

Claimant's Proof of Loss

Patient Name: _____ Date of Birth: _____

Relationship to Insured: _____

Address: _____
Street City State Zip Code

Social Security No: _____ Telephone No: _____

THIS SECTION MUST BE COMPLETED BY THE AUDIOLOGIST/OTOLOGIST

1. Name of Examiner: _____ License No: _____
2. Date of Most Recent Hearing Aid Test: _____
3. Date of Prescription for Hearing Aid: _____
4. In my professional opinion, a hearing aid ❑ is required ❑ is not required
5. Hearing Loss (%) Left Ear_____ % Right Ear_____ %

THIS SECTION MUST BE COMPLETED BY THE HEARING AID DEALER

1. Hearing Aid Center: _____ License No: _____
2. Hearing Aid Type or Mode: _____
3. Cost of Hearing Aid Appliance $ _____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE DIAGNOSIS TO PROCEDURE BELOW)

Date(s) of Service MM DD YY	Place of Service	Type of Service	Modifier	Procedures, Services, or Supplies CPT or HCPCS Code	Diagnosis Code	Charges	Or Units	Leave Blank

Federal Tax I.D. Number SSN ❑ EIN ❑	Patient's Account No.	Accept Assignment? ❑ YES ❑ NO	Total Charges $	Amount Paid $	Balance Due $

Signature of Physician or Supplier Including Degrees or Credentials	Name and Address of Facility Where Services Were Rendered (if other than home or office)	Physician's, Supplier's Billing Name, Address, Zip Code and Phone #
Signed _____ Date _____		PIN # _____ GRP # _____

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above-named patient.

Subscriber Signature _____ Date _____

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

How to File a Claim for Your Dental, Vision and Hearing Policy

Hearing

Claim Filing

We accept the HCFA 1500 (Health Care Financial Administration) Standardized health insurance claim form or the Hearing Claim at www.manhattanlife.com

Your policy will considered charges for hearing exams due to hearing loss and the cost of hearing aids.

In the information section of the form, you or your physician must fill in the following information.

- Insured full name and address
- Insured's policy number
- The name and date of birth of the insured receiving the hearing services.

If your hearing care provider files the claim for you

Many audiologists and otologists will file the claim on your behalf. Many may ask that you pay your share of the cost at the time of the visit. Show your ManhattanLife Assurance Company of America ID card to your hearing care provider.

Attachment of Supporting Documentation for Vision and Hearing Claims

You should substantiate your claim expenses by attaching itemized bills and receipts, which contain the following information.

- Insured's full name and address
- Insured's ID number
- Provider's name and address
- Dates that care or treatment was provided
- Physician'a and/or Retailer's Tax ID Number
- Dates that hearing aids and/or glasses/contacts were purchased
- ICD diagnosis codes
- CPT/HCPCS procedure codes
- Description of each treatment
- Charge for each service.

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