HCS Member Reimbursement Form

Section 1: Member Information

Last name	First name	M.I.	Gender	Member ID no.

Street Address	City	State	Zip Code

Section 2: Provider Information

Last name	First name	Practice Name

Street Address	City	State	Zip Code

Section 3: Diagnosis

What is the illness or injury requiring treatment?

Section 4: Cost to the patient

Cost of hearing aids	Cost of testing	Cost of batteries

☐ Assignment of benefits to provider (Only check this box if we should pay the provider and not you as a member)

Section 5: Authorization and Signature Required

Patient signature	Date

Please submit the following documents for reimbursement:

- Completed reimbursement form (this document)
- Copy of completed purchase agreement
- Copy of itemized receipt

Please send requested documentation via any of the following methods:

- Email: claims@hearingcaresolutions.com
- Fax: 303-889-5137
- Mail: **Hearing Care Solutions**
  5889 Greenwood Plaza Blvd
  Ste 300
  Greenwood Village, CO 80111
  ATTN: CLAIMS

Questions: Please call (855) 998-6769