



MEDICAL MUTUAL OF OHIO®

2060 East Ninth Street
Cleveland, Ohio 44115-1355

HEARING CLAIM FORM

PART I PATIENT AND CERTIFICATE HOLDER INFORMATION		<i>(Please Print or Type)</i>
1. Certificate Holder's Name _____ Address _____ City _____ State _____ Zip _____ Phone (_____) _____	6. Patient's date of birth Age / /	<p style="text-align: center;">** IMPORTANT **</p> If the patient is covered by any other group or non-group health insurance, including Medical Mutual of Ohio™, please complete this section. Name of other employer _____ Address of other employer _____ Name of other person employed _____ Birthdate of other person employed _____ Relationship to patient _____ Other health care plan _____ If the patient is a child and parent's are divorced, please answer the following: a. Which parent has custody of the patient? _____ b. Is there a court decree that states which parent is responsible for medical bills? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please attach a copy of the court decree.
2. Patient (first name, middle initial, last name) _____	7. Patient's relation to Certificate Holder self (male) self (female) husband 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> wife son daughter 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> other male dependent other female dependent 7 <input type="checkbox"/> 8 <input type="checkbox"/>	
3. Certificate Holder's ID number: _____ Medical Mutual of Ohio™ Plan code: _____ <small>(Numbers can be found on Certificate Holder's ID card)</small>	8. Is patient full-time student 19 years of age or older? <input type="checkbox"/> yes <input type="checkbox"/> no Name of school: _____	
4. Group name: _____ 5. Group number: _____	9. Was condition related to: A. Employment <input type="checkbox"/> yes <input type="checkbox"/> no B. Accident <input type="checkbox"/> yes <input type="checkbox"/> no Date of Onset: _____	
5a. I authorize release of any information relative to this claim to be used by Medical Mutual of Ohio™ or a review agency with which it has contracted solely for the purposes of determining reimbursement. _____ DATE: _____ <small>(Signature of Certificate Holder or Spouse)</small>		

NOTE: For this claim to be considered for payment, it must be accompanied by a "Certificate of Need" from a physician stating that a hearing aid would compensate for the loss of hearing.

PART II PHYSICIAN OR PROVIDER INFORMATION				<i>(To be completed by physician or provider only)</i>			
13. Date symptom first appeared:	14. Date patient first consulted you for this condition:	15. Has patient ever had symptoms? <input type="checkbox"/> yes <input type="checkbox"/> no	16. Referring physician:				
17. Name and address of facility where service was rendered (other than home or office):		18. Is patient total disabled? <input type="checkbox"/> yes <input type="checkbox"/> no	Dates of total disability: From To				
19. A medical examination verifying hearing loss was performed on _____ by _____							
20. A Date of service	B Place of service (see back)	C Type of service	D Description: Explain unusual services or circumstances related to procedures, medical services or supplies furnished for each date given	E Diagnosis code ICD-9-CM	F Charges	G Days or Units	H (Internal use only)
		Audiometric Exam					
		Hearing Aid Evaluation					
		Hearing Aid Acquisition Cost	Type _____ Model _____				
		Hearing Aid Dispensing Fee					
		Conformity Evaluation					
		Sales Tax					
Internal use only					21. Total charges		To make payment, your taxpayer identification number must be in Block 23.
22. Patient account number			23. Identification number or (taxpayer ID)				

I certify that these services were performed by me or in my presence under my supervision 	24. Physician/provider name _____ Address _____ City _____ State _____ Zip _____ Signature _____
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FOR THE CERTIFICATE HOLDER

1. Use this form for all your hearing claims. Use a separate form for each patient and each physician.
2. Complete all items on Part 1 of the form for both the patient and the Certificate Holder. If any information is missing a delay in processing will result. Make sure you sign the form in Block #5A to authorize release of information.
3. After completion of Part 1 give the form to your physician.

FOR THE PHYSICIAN OR PROVIDER

1. Use a separate claim form for each patient and each provider rendering service. If you are a member of a group practice, the services of all physicians in your group can be reported on one claim if the first 11 digits of their ID number is the same.
2. Review the top of the form to make sure the employee has provided all information, especially Coordination of Benefits (Block 10) and a signature (Block 5A). Missing information will cause a delay in processing.
3. Complete Part II with all information pertinent to the patient's treatment. Be sure to indicate the type of procedure coding used.
4. Be sure to use your taxpayer ID number in Block 23.

PLACE OF SERVICE CODES	
1-(IH)	- INPATIENT HOSPITAL
2-(OH)	- OUTPATIENT HOSPITAL
3-(O)	- DOCTOR'S OFFICE
4-(H)	- PATIENT'S HOME
5-	- DAY CARE FACILITY (PSY)
6-	- NIGHT CARE FACILITY (PSY)
7-(NH)	- NURSING HOME
8-(SNF)	- SKILLED NURSING FACILITY
9-	- AMBULANCE
0-(OL)	- OTHER LOCATIONS
A-(IL)	- INDEPENDENT LABORATORY
B-	- OTHER MEDICAL/SURGICAL FACILITY
C-	- DENTAL OFFICE
D-	- INPATIENT DRUG FACILITY
E-	- OUTPATIENT DRUG FACILITY
F-	- INPATIENT PSYCHIATRIC
G-	- HEMOPHILIA TREATMENT CENTER
H-	- HOSPICE FACILITY

ATTENTION CERTIFICATE HOLDERS:

Use this form to file for hearing expenses. These charges may be accumulated until you reach your deductible amount or filed separately. The physician does not need to complete Part II. A separate form must be completed for each patient.

Each statement must be itemized and contain the following information:

- Name of patient
- Date of each service
- Charge for each service
- Type of treatment

Claim Form Submission Checklist

To ensure claims are processed properly and efficiently, the claim form *must* include the following information:

- Identification Number
- Insured's Name (Policyholder)
- Patient's Name
- Patient's Date Of Birth
- Patient's relationship to cardholder
- Date(s) Of Service
- Procedure Code (CPT/HCPCS)
- Diagnosis Code (ICD-9 Code)
- Total Charge (breakdown of charges if applicable)
- Provider Information:
 - Name
 - Tax Identification Number and NPI (if available)
 - Servicing Address
 - Billing Address

Please Note:

- Ensure all documents are legible.
- Upon completion of the form, it is advisable to make a copy for your records prior to mailing.
- If you have primary insurance with another carrier, include a copy of the primary explanation of benefits.
- For **Foreign Claims**, include all of the above information, as well as:
 - Country where services were rendered
 - Original receipts
 - Total Charges (converted to US Currency)
 - To expedite the processing of your claim, and to make sure we have accurate information, we suggest that all billings submitted for consideration be translated into English.