UNITED SECURITY INSURANCE COMPANY®
PO BOX 388199 • CHICAGO, IL 60638
Phone: 800-875-4422 • 708-475-6100
Fax: 708-475-6120

HEARING AND VISION CLAIM FORM

*Attach Receipts for Payment of Charges

CLAIMANT'S PROOF OF LOSS:

Insured's Name: _____ Date of Birth: _____ Policy #: _____

Address: _____
Street City State ZIP Code

Telephone #: _____ Social Security #: _____

PATIENT INFORMATION:

Patient's Name: _____ Date of Birth: _____
Last Name First Name Month / Day / Year

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Sex: ☐ Male ☐ Female

VISION:

1.) Date of Exam: _____ 2.) Place of Service: _____

HEARING:

THIS SECTION MUST BE COMPLETED BY THE AUDIOLOGIST / ORTOLIGIST

1.) Name of Examiner: _____ License #: _____

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 #: _____

2.) Hearing Aid Type or Model: _____ 3.) Cost of Hearing Aid Appliance $_____

HEARING / VISION SERVICES RENDERED: (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 ID #: ☐SSN ☐EIN	PATIENT'S ACCOUNT #:	ACCEPT ASSIGNMENT? ☐YES ☐NO (for government claims)	TOTAL CHARGES $	AMOUNT PAID $	BALANCE DUE $
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS SIGNED_____ DATE_____	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	PHYSICIANS SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # 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 _____

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.