



United Security Life and Health Insurance Company  
 P.O. Box 24655  
 Seattle, WA 98124-0655

Customer Service: 1-800-875-4422

**\*Attach Receipts for Payment of Charges**

Claim Form – Vision/Hearing

Insured's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Policy No: \_\_\_\_\_

Address: \_\_\_\_\_  
 Street City State Zip Code

Social Security No: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_  
 Last Name First Name

Patient's Relationship to Insured: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Self  Spouse  Child  Other  Male  Female Month/Day/Year

**VISION:**

- 1.) Date of Exam: \_\_\_\_\_
- 2.) Place of Service: \_\_\_\_\_

**HEARING:**

**THIS SECTION MUST BE COMPLETED BY THE AUDIOLOGIST/ORTOLOGIST**

- 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 Model: \_\_\_\_\_
- 3.) Cost of Hearing Aid Appliance \$ \_\_\_\_\_

**HEARING/VISION SERVICES RENDERED:**

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	

FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		PATIENT'S ACCOUNT NO.	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 and paid by the above-named patient.

Insured 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.**