Healthplex®
Leadership in Dental Plans

COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY, INC.
Hearing-Aid Benefit Claim Form

To receive your Hearing Aid Benefit you must:

1. Complete this form.
2. Attach an itemized bill or receipt from the Provider of Service for all eligible expenses containing the following information. Cancelled checks are not acceptable.
   - Name of person and date hearing aid was received
   - Amount Paid
   - Name of provider rendering service
3. Mail completed form and attachment to:

   Healthplex, Inc.
   Attn: Claims
   333 Earle Ovington Blvd., Suite 300
   Uniondale, NY 11553-3608
   Providers Call – (888) 468-2183 Press Option 1 for IVR or Option 3
   Members Call – (888) 468-5178 Press Option 1

Member Information

Please Print

Employment Status

☐ Active ☐ Retiree ☐ Part-Time

Member's Social Security Number ______________________________

Member's Name ______________________________

Member Address ______________________________
Street

____
City State Zip Code

☐ Check here if this is a new address

Hearing Aid Benefit Information

Name	Date of Birth	Relationship To Member	Date Received	Provider's Name	Amount of Claim
				Total ______

I hereby request payment for the above claimed expenses. I certify that either my eligible dependent(s) or I have incurred these expenses and have not been previously reimbursed.

Member's Signature ______________________________ Date ______________