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
   - Proof of medical necessity
3. Mail completed form and attachment to:

   Attention: Claims Dept.
   PO Box 9255
   Uniondale, NY 11553-9255
   Providers Call – (888) 468-2183 Press Option 1 for IVR
   Members Call – (888) 468-5178

Member Information – Please Print

Employment Status

☐ Active ☐ Retiree ☐ Part-Time

Patient Name _____ Date of Birth _____

Member's Identification # _____

Member's Name _____

Member's Address _____
Street

_____
City State Zip Code

☐ Check here if this is a new address

Provider Name _____

Provider Address _____
Street

_____
City State Zip Code

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 _____