# CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

P.O. BOX 2280 • OAKLAND, CA 94614-0180 • TELEPHONE (510)633-0333 – (888) 547-2054

## HEARING AID BENEFIT CLAIM

### INSTRUCTIONS

1. Carpenter must complete PART I and must personally sign this form.
2. PART II is to be completed by Provider of Service.
3. Benefits are available upon dispensing of item, not on order date.

**KAISER PARTICIPANTS MUST USE KAISER FOR HEARING AID BENEFIT.**

## PART I PLEASE PRINT OR TYPE.

**CARPENTER**

| CARPENTER'S NAME LAST | FIRST | MIDDLE | BIRTHDATE MO DAY YEAR | RETIRED? ☐ YES ☐ NO | CARPENTER'S SOCIAL SECURITY NO. |
|---|---|---|---|---|---|
| | | | | | ___ ___ ___ ___ ___ ___ ___ ___ ___ |

| ADDRESS NUMBER | STREET | CITY | STATE | ZIP CODE |
|---|---|---|---|---|
| | | | | |

| PATIENT'S NAME | BIRTHDATE MO DAY YEAR | PATIENT'S RELATIONSHIP TO CARPENTER ☐ SELF ☐ SPOUSE ☐ CHILD | ☐ MALE ☐ FEMALE |
|---|---|---|---|
| | | | |

| Is Any Member of Your Family covered by any other Health Insurance Group Plan? If Yes, Furnish Details Below. ☐ YES ☐ NO | INDICATE IF FULL TIME STUDENT SCHOOL |
|---|---|
| | |

| PLEASE PROVIDE NAME AND ADDRESS OF **OTHER** PLAN OR GROUP | GROUP NO. OR POLICY NO. |
|---|---|
| | |

| NAME OF EMPLOYER OR ORGANIZATION PROVIDING OTHER COVERAGE | NAME OF PRIMARY PERSON COVERED UNDER OTHER PLAN | IDENTIFYING NO./S.S.# OF PRIMARY PERSON COVERED UNDER OTHER PLAN |
|---|---|---|
| | | ___ ___ ___ ___ ___ ___ ___ ___ ___ |

I certify under penalty of perjury under the laws of the State of California that the information given on this claim is true and correct. I authorize the Provider of Service to release all information relating to this claim.

CARPENTER'S SIGNATURE _____ DATE SIGNED _____ 20____

## PART II PLEASE PRINT OR TYPE.

**PROVIDER OF SERVICE**

| EXAM YES ☐ NO ☐ | | DATE OF SERVICE MO DAY YEAR | AMOUNT CHARGED |
|---|---|---|---|
| | | | |
| LEFT SERIAL NUMBER | DATE ORDERED MO DAY YEAR | DATE DELIVERED MO DAY YEAR | AMOUNT CHARGED |
| | | | |
| RIGHT SERIAL NUMBER | DATE ORDERED MO DAY YEAR | DATE DELIVERED MO DAY YEAR | AMOUNT CHARGED |
| | | | |

| NAME OF PROVIDER | FEDERAL I. D. NUMBER | TELEPHONE NUMBER |
|---|---|---|
| | | ( ) |

| ADDRESS STREET | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| AUTHORIZED SIGNATURE OF PROVIDER | DATE SIGNED |
|---|---|
| | |

**CLAIMS MUST BE FILED WITHIN 90 DAYS FROM DATE SERVICE RENDERED.**
**(FUND BENEFITS WILL BE PAID DIRECTLY TO THE CARPENTER ONLY.)**

*If a Prudent Buyer provider is available to the participant and is utilized, benefits will be paid to the provider.*