



## HCS Member Reimbursement Form

### Section 1: Member Information

Last name	First name	M.I.	Gender	Member ID no.
Street Address		City	State	Zip Code

### Section 2: Provider Information

Last name	First name	Practice Name		
Street Address		City	State	Zip Code

### Section 3: Diagnosis

What is the illness or injury requiring treatment?
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### Section 4: Cost to the patient

Cost of hearing aids	Cost of testing	Cost of batteries
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☐ Assignment of benefits to provider (Only check this box if we should pay the provider and not you as a member)

### Section 5: Authorization and Signature Required

Patient signature	Date
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Please submit the following documents for reimbursement:

- Completed reimbursement form (this document)
- Copy of completed purchase agreement
- Copy of itemized receipt

Please send requested documentation via any of the following methods:

- Email: [claims@hearingcaresolutions.com](mailto:claims@hearingcaresolutions.com)
- Fax: 303-889-5137
- Mail: **Hearing Care Solutions**  
5889 Greenwood Plaza Blvd  
Ste 300  
Greenwood Village, CO 80111  
ATTN: CLAIMS

**Questions:** Please call (855) 998-6769