m.k.larson audiology

A FAMILY DIAGNOSTIC & HEARING AID PRACTICE

Insurance Hearing Aid Benefit

☐ E-Billed ☐ WIP ☐ Pending ☐ Patient Canceled ☐ Paid

Date _____ Patient Name _____ DOB _____

Insurance _____ ☐ Primary ☐ Secondary

IDb # _____ Group # _____ Effective Date _____ Plan _____

Diagnostic Benefit _____ % _____ HAS $ _____

% Covered _____ Months/Years _____

Deductible _____ Met $ _____ Remaining Deductible $ _____

Out of Pocket $ _____ Met $ _____ Remaining Out of Pocket $ _____

Customer Service Number Called/Website _____

Payer ID # _____ (If new insurance and not already in Sycle)

Send Claims To (If cannot be done electronically)

_____

_____

Coinsurance $ _____ Copay $ _____ In Network / Out of Network

Patient Is Eligible for HAS (Date) _____ Last Billed (Date)_____

Notes_____

_____

_____

_____

Reference # _____ Spoke With _____

CALL LOG

Date _____ Spoke With _____ Ref #_____

Action _____

Date _____ Spoke With _____ Ref #_____

Action _____

Date _____ Spoke With _____ Ref #_____

Action _____

Date Paid _____ Amount Paid $ _____ Check/EFT

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