Priority Health

Out-of-network hearing claim form (Medicare)

- Use this form to request reimbursement for hearing devices and related audiology services received.
- Make sure that all sections are completed, that you and the provider have signed the form and all products/services, costs and service dates are enclosed on a detailed purchase receipt.
- Please note that both the member's signature and the service provider's signature are required on this form.
- ***NOTE: This form is not required for in-network purchases/services; contact Priority Health Hearing for network providers at 888.389.6648 (TTY users should use 711), seven days a week, 8 a.m. to 8 p.m. EST.***

Member information

First name: _____ Last name: _____

Priority Health member ID#: _____ Date of birth: _____

Address: _____ City: _____ State: _____ ZIP: _____

Member signature: _____ Date: _____

I certify that the information on this form and the product/service information on the enclosed purchase receipt is correct.

Provider information

Remit/billing name: _____ Billing NPI # (type 2): _____

Tax ID: _____ Provider name: _____

Audiology NPI # (type 1): _____ Audiology license #: _____

Address: _____ City: _____ State: _____ ZIP: _____

Provider signature: _____ Date: _____

I certify that the information on this form and the product/service information on the enclosed purchase receipt is correct.

NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person, who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Complete this form and submit with a copy of the detailed purchase receipt/bill to:
Priority Health
ATTN: Claims
1231 East Beltline NE
Grand Rapids, MI 49525