Aetna Health
Hearing Aid Statement of Satisfaction Form

This form must be filled out **after the 30-day trial period for hearing aid services**, and returned to *Aetna Health, PO Box 981107, El Paso, TX 79998-1107*, before we can process a request for reimbursement. Both the member and the provider must sign at the appropriate areas below.

Completion of the Statement of Satisfaction Form allows for the proper application of the hearing aid benefit.

Member Name: _____ Date of Birth: _____

Member ID#: _____ Phone Number: _____

Member Address: _____

Provider Name: _____

Provider Address: _____

Hearing Aid(s) make and model: _____

Serial Number (s): _____

_____ Right Ear _____ Left Ear _____ Both Ears

$ _____ Total Price $ _____ **Allowance (submitted for reimbursement)** $ _____ Member responsibility	Who should receive Reimbursement for Balance? Circle one: Member OR Provider

_____ Provider Signature _____ Date

FOR MEMBER:
Please read the statements below before signing:
My signature below hereby confirms that the hearing aid services and the hearing aid(s) provided to me are satisfactory. The provider has instructed me in the following:

- Use, care, and adjustment of the hearing aid(s).
- Warranty information and loss and damage insurance.
- Potential benefits and limitations.
- Verification of the fitting using real ear measurements.
- No additional charge for adjustments and repairs for one year post fitting date.
- I have been given a hearing aid benefit questionnaire.

_____ Member Signature _____ Date

Updated 02-02-05 by Ed Leihy
(New Claims Address)