Keystone Health Plan East

CHIP Hearing Aid Reimbursement Form

Please fill out the following information:

Child's Name: _____ **Gender:** Male Female

Member ID Number: _____ **Date of Birth:** _____

Cost of Hearing Aid(s): _____ **Date of Service:** _____

Purchased a hearing aid for which ear? *(circle one)*

Right Left Both

Diagnosis Code: _____ Procedure Code: _____ Relationship Code: _____
Provider Number: _____ Place of Service Code: _____
Batch Category: _____

Send this completed form and your paid receipt by fax or mail to:

Attention: Customer Service Supervisor

Fax: 215-241-3679

or

Mail: Independence Blue Cross
Government Markets Department – CHIP Member Help Team
1901 Market Street. 11th floor
Philadelphia, PA 19103

If you have any questions about how to complete this form or the CHIP hearing aid reimbursement process, please contact our CHIP Member Help Team at 1-800-464-5437 (TTY/TDD: 711), Monday through Friday from 8 a.m. to 6 p.m.