

## Keystone Health Plan East

### CHIP Hearing Aid Reimbursement Form

Please fill out the following information:

<b>Child's Name:</b> _____	<b>Gender:</b> Male      Female
<b>Member ID Number:</b> _____	<b>Date of Birth:</b> _____
<b>Cost of Hearing Aid(s):</b> _____	<b>Date of Service:</b> _____
<b>Purchased a hearing aid for which ear? (circle one)</b>	
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, 11<sup>th</sup> 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.

Benefits underwritten and/or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross, independent licensees of the Blue Cross and Blue Shield Association. Independence Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-275-2583 (TTY/TDD: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-275-2583 (TTY/TDD : 711)。