Administrative Services Only, Inc
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CWA LOCAL 1181 SECURITY BENEFIT FUND
HEARING BENEFIT CLAIM FORM

Please visit www.asonet.com and log into your member account for additional plan information, to print claim forms, track your claims and claim history, and to print your ID card, which will have your ASO member ID number.

MEMBER INFORMATION

MEMBER NAME:	BIRTH DATE:	LAST 4 DIGITS OF SOC SEC # OR ASO MEMBER ID #		
ADDRESS:	APT. NO.	CITY:	STATE:	ZIP CODE:
PERSONAL EMAIL ADDRESS:		HOME PHONE:	CELL PHONE:	

PATIENT NAME:	BIRTH DATE:	RELATIONSHIP: ☐ MEMBER ☐ SPOUSE/DOMESTIC PARTNER ☐ DEPENDENT

Who is Covered? Hearing aid benefits are available for members, their spouse/domestic partner and eligible dependent children.

What is the Maximum Benefit? Active and Retired Members, their spouse/domestic partner and eligible dependent children are reimbursed up to a maximum of $1,000.00 once every three calendar years if same have not been reimbursed via your health insurance plan.

What Services Does the Plan Cover? The hearing aid plan covers otologic hearing examinations performed by a physician, surgeon or audiologist; and hearing aid appliances prescribed by a qualified physician or audiologist if not covered under the health plan.

Exclusions- No benefit will be paid for:

- expenses not recommended or approved by a physician, otologist, or audiologist;
- non-durable equipment, such as batteries;
- special procedures or training, such as lip-reading courses, schooling, or institutional expenses;
- medical or surgical treatment of the ear or ears; or
- expenses for which benefits are payable under any other plan or coverage.

How to File a Claim

- Complete the CWA Local 1181 Security Benefit Fund Hearing Aid Claim Form.
- Attach all supporting documentation, receipts and explanation of benefit vouchers from all other carriers, if applicable.
- Claims must be submitted within six (6) months of date of service.
- Sign and submit it to: **Administrative Services Only, Inc.**

AUTHORIZATION TO RELEASE INFORMATION: MEMBER'S SIGNATURE IS REQUIRED ON ALL CLAIMS.
I hereby authorize any insurance company, prepayment organization, employer, healthcare provider, or the Board of Trustees of the CWA Local 1181 Security Benefit Fund to release all information with respect to myself or any of my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

_____ _____
SIGNATURE OF MEMBER **DATE**