

Commonwealth of Massachusetts/ NAGE HEALTH and WELFARE TRUST FUND Hearing Aid Assistance Program

Return Form To: Commonwealth of Massachusetts/NAGE
Hearing Aid Assistance Program
159 Burgin Parkway, First Floor
Quincy, MA 02169-4213

Benefit for Hearing Aid Device Only
There is no coverage for the hearing test
Maximum benefit \$1000.00 once every three years

The Commonwealth of Massachusetts/NAGE Health and Welfare Trust Fund is your secondary insurance on a hearing aid device. You must submit your paid bills to the Group Insurance Commission or your health insurance carrier for payment first. Any remaining balance of your hearing aid device must then be submitted to the NAGE Fund Office with this completed claim form.

The NAGE Fund Office will not process any claims until all payments have been received from your health insurance carrier.

Please Print: To be completed by eligible members of NAGE or its affiliates, with collectively bargained agreements

1. Employee's Full Name: _____

Employee Social Security Number: _____ Sex: _____ Date of Birth: _____

Home Mailing Address: _____
number and street

city, state and zip code

Telephone Number: (work) _____ ext. _____ (home) _____

2. If a claim is for a dependent, give name: _____

Relationship: _____ Date of Birth: _____

Note: To receive benefits under this plan, services must be completely paid to the provider before submitting this claim form. Please attach an itemized statement as well as the explanation of benefit from your health insurance carrier. The following information must be provided: name of patient, name of Insured member, name and address of the provider, date of service, a list of the itemized services provided and each associated charge with written confirmation of payment for the services.

If all questions are not answered, and if a copy of a paid statement or bill is not included, this claim will not be processed.

If you have any questions, please contact the NAGE Fund Office at 1-800-641-0700

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any provider named to disclose all known facts concerning this claim. A copy or photocopy of this authorization shall be valid as the original.

Signed: _____ Date: _____
signature of member

Signed: _____ Date: _____
signature of hearing aid device provider

It is illegal for a Fund member to willfully and knowingly misrepresent any fact for the purpose of securing benefit under any of the Fund's plans. Any member found by the Board of Trustees to have committed such a misrepresentation may immediately become ineligible for benefits, and will be required to reimburse the Fund for any benefits so obtained. The Trust Fund will cooperate with law enforcement agencies investigating and prosecuting criminal complaints, including fraud or larceny.