U.C.E. OF F.I.T. WELFARE FUND

SEND COMPLETED FORMS TO: THE SENECA GROUP, INC
PO Box 1043
Matthews, NC 28106
or fax with a copy of the receipt to: **866-223-6521**

HEARING AID VOUCHER

IF YOU GO PRIVATELY, PLEASE RETURN THIS VOUCHER WITH PAID BILL

TO BE COMPLETED BY PROVIDER

Name of Patient:: _____ Date of Birth: _____

Date of Service: _____

SERVICES RENDERED

I RECOMMEND THAT THIS PATIENT OBTAIN THE FOLLOWING TYPE HEARING AID:

☐ Examination Recommended ☐ Right Ear ☐ Left Ear ☐ Both Ears

Battery Power _____ Brand/Model _____

Signature of Doctor/Provider _____

Firm Name _____

Address _____

ELIGIBILITY CERTIFICATION

Member Social Security # _____

Patient Name _____ Male ☐ Female ☐

Relationship to Member _____ Home Telephone # _____

Date of Voucher _____ Approved by _____

THIS VOUCHER IS VALID FOR 60 DAYS FROM ABOVE DATE

Member Name _____ Active ☐ Retiree ☐

Address _____ Full-Time ☐ Part-Time ☐

TO RECEIVE PROMPT PAYMENT, FORM *MUST* BE FILLED OUT IN ITS ENTIRETY