UNITED SECURITY
HEALTH AND CASUALTY INSURANCE COMPANY
SIMUL, NOS VIAM INVENIENT

United Security Health and Casualty Insurance Company
P.O. Box 388199
Chicago, IL 60638

Customer Service: 1-800-875-4422

*Attach Receipts for Payment of Charges
Claim Form – Vision/Hearing

CLAIMANT'S PROOF OF LOSS

Insured's Name: ___________________________ Date of Birth: ______________ _ Policy No: ______ ________________________

Address:
____
Street City State Zip Code

Social Security No: ______________________________

Telephone #: _________________________________

PATIENT INFORMATION

Patient's Name:
____ ________________________
Last Name First Name

Patient's Relationship to Insured: Self Spouse Child Other
Sex: Male Female
Date of Birth: ___________________________ Month/Day/Year

VISION:

1.) Date of Exam: ___________________________________
2.) Place of Service: _________________________________

HEARING:

THIS SECTION MUST BE COMPLETED BY THE AUDIOLOGIST/ORTOLOGIST

1.) Name of Examiner: ______________________________ License No.: ___________________
2.) Date of Most Recent Hearing Aid Test: ____
3.) Date of Prescription for Hearing Aid: ____
4.) In my professional opinion, a hearing aid **is required** **is not required**
5.) Hearing Loss (%) Left Ear _______% Right Ear _______%

THIS SECTION MUST BE COMPLETED BY THE HEARING AID DEALER

1.) Hearing Aid Center: _________________________________ License No: _______________
2.) Hearing Aid Type or Model: ____________________________
3.) Cost of Hearing Aid Appliance $_________________________

HEARING/VISION SERVICES RENDERED:

(RELATE DIAGNOSIS TO PROCEDURE BELOW)

DATE(S) OF SERVICE MM DD YY	PLACE OF SERVICE	TYPE OF SERVICE	MODIFIER	PROCEDURES, SERVICES, OR SUPPLIES CPT OR HCPCS CODE	DIAGNOSIS CODE	CHARGES	OR UNITS	LEAVE BLANK

FEDERAL TAX I.D. NUMBER SSN EIN	PATIENT'S ACCOUNT NO.	ACCEPT ASSIGNMENT? (for government claims) YES NO	TOTAL CHARGES $	AMOUNT PAID $	BALANCE DUE $
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS SIGNED DATE	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	PHYSICIANS SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # PIN # GRP #			

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above-named patient.

Subscriber Signature _______________________________ ________ Date ____________________________________

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.