

**Wyoming Miners' Hospital Board  
Hearing Aid Assistance Program  
Claim Form**

Group Number 0004463

**Miner: This section to be completed by the Miner**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

I authorize release of any and all medical records related to the evaluation and purchase of a hearing aid through the Wyoming Miners' Hospital Board Hearing Aid Purchase Assistance Program to EBMS, Inc.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PROVIDER INFORMATION & CLAIM FORM**

**This section to be completed BY THE AUDIOLOGIST OR HEARING AID SPECIALIST**

**IMPORTANT NOTE TO PROVIDERS & MINERS: WYOMING MINERS' HOSPITAL BOARD HEARING AID PURCHASE ASSISTANCE PROGRAM PAYS DIRECTLY TO THE PROVIDER & DOES NOT REIMBURSE THE MINER.**

**I am an Audiologist or Hearing Aid Specialist. I evaluated the above named miner on \_\_\_\_\_  
And my recommendation is as follows: (Please attach Audiogram)**

He/She is a candidate for a hearing aid/aids in the: \_\_\_\_\_ Right Ear \_\_\_\_\_ Left Ear \_\_\_\_\_ Binaural

Right Ear: \_\_\_\_\_

Make: \_\_\_\_\_ Model#: \_\_\_\_\_ Serial#: \_\_\_\_\_ Charge \$ \_\_\_\_\_

Left Ear: \_\_\_\_\_

Make: \_\_\_\_\_ Model#: \_\_\_\_\_ Serial#: \_\_\_\_\_ Charge \$ \_\_\_\_\_

TOTAL \$ \_\_\_\_\_

The Wyoming Miners' Hospital Board Hearing Aid Purchase Assistance Program Benefit will be paid to:

Name: \_\_\_\_\_ License/Registration#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

As the provider, I understand that should the hearing aid be returned within the 30-day money back guarantee period, I will refund the benefit to the program at the address below.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please send this Claim Form and direct questions to:

**EBMS, Inc.**  
**P.O. Box 21367**  
**Billings, MT 59104-1367**  
**Toll Free (877) 240-2435 • Fax (406) 652-5380**