



# ESCO Reminder Care Patient Sign-Up

ESCO's Reminder Care program will help your patients keep track of when it is time to protect their investment in hearing instruments with extended loss and damage coverage. Use this form to sign your patients up for this service. Just prior to the expiration of your patient's original manufacturer's warranty, ESCO will send them a note reminding them to extend their coverage through ESCO with you as their provider.

Office Name: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ This form prepared by: \_\_\_\_\_

ESCO Center Number: \_\_\_\_\_ Reporting Period: \_\_\_\_\_  
(Please call ESCO to obtain center number) From To

| Patient   |       | Style             |     |     |    |     |    |     | Hearing Device Specifics   |       |          |               |   |
|---|-------|-------------------|-----|-----|----|-----|----|-----|--|-------|----------|---------------|---|
| <i>Please provide patient name, street address, city/state/zip, and phone number.</i> |       | <i>Check one.</i> |     |     |    |     |    |     | <i>Please take care to provide complete information. It will help us better serve you!</i> |       |          |               |   |
|   |       | BTE               | OTE | ITE | HS | ITC | MC | CIC | Manufacturer   | Model | Serial # | Purchase Date | Expiration Date of<br>Manf. Loss & Damage |
| <b>1</b> Name:<br>Address:<br>City/State/Zip:<br>Phone Number:                        | Right |                   |     |     |    |     |    |     |  |       |          |               |   |
|   | Left  |                   |     |     |    |     |    |     |  |       |          |               |   |
| <b>2</b> Name:<br>Address:<br>City/State/Zip:<br>Phone Number:                        | Right |                   |     |     |    |     |    |     |  |       |          |               |   |
|   | Left  |                   |     |     |    |     |    |     |  |       |          |               |   |
| <b>3</b> Name:<br>Address:<br>City/State/Zip:<br>Phone Number:                        | Right |                   |     |     |    |     |    |     |  |       |          |               |   |
|   | Left  |                   |     |     |    |     |    |     |  |       |          |               |   |
| <b>4</b> Name:<br>Address:<br>City/State/Zip:<br>Phone Number:                        | Right |                   |     |     |    |     |    |     |  |       |          |               |   |
|   | Left  |                   |     |     |    |     |    |     |  |       |          |               |   |
| <b>5</b> Name:<br>Address:<br>City/State/Zip:<br>Phone Number:                        | Right |                   |     |     |    |     |    |     |  |       |          |               |   |
|   | Left  |                   |     |     |    |     |    |     |  |       |          |               |   |

Use this form to provide your patients the convenience of a reminder notice that will alert them when it is time to consider extended coverage. Mail or FAX your patient's information on this form to ESCO to sign up for this FREE service.



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