



ESCO Claim Form

An incomplete claim form will delay your claim.

Please complete the Policy Holder/Claim Information requested below. Have your Practitioner complete the Hearing Instrument Information section and send a copy of this claim form to ESCO within 90 days of the occurrence. **Both the Policy Holder AND the Practitioner's signatures are required** before ESCO can process your claim. Once processed, ESCO will send a letter regarding the status of your claim to you, the policy holder, at the mailing address shown below and to the practitioner.

Policy Holder/Claim Information

The information below is to be completed by the hearing instrument wearer or the parent/guardian of the wearer. Please pay particular attention to the items near the **five circled numbers below** that are essential to processing your claim.

1 Wearer Name _____

Guardian Name _____
(If applicable)

Mailing Address _____

City/State/Zip _____

Phone Number _____

2 Date loss, damage, or breakdown event occurred/was discovered _____
(Specific month/day/year required)

3 The reason for your claim (select one)
 Loss (Describe the events surrounding the loss)

Accidental Damage
(Describe the unintentional events surrounding the damage)

Repair/Normal Wear & Tear
(Describe the malfunction—for example, component failure.)

4 Do you have other insurance that may cover this claim?
 Yes _____ No
If yes, please provide the company name and policy number

Sworn Statement Signatures

I certify that the information on this form is true and correct. I further understand that filing a dishonest or fraudulent claim is unlawful. The Wearer requests ESCO to send the authorization letter to the Practitioner named on this form.

5 Wearer Signature _____ Date _____
(Or guardian)

D Practitioner Signature _____ Date _____

Hearing Instrument Information

The information below is to be completed by the Practitioner. Areas marked by **arrows A - D** (below and to the left) are essential to processing this claim. Please reverse for additional claim procedure information.

Policy # _____

Please supply the information regarding each claimed device:

A Specifics	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear
Serial #		
Model		
Manufacturer		

Style (Check the appropriate box.)
 BTE OTE/Open Fit ITC HS
 ITE CIC MC Other _____
 Remote /Transmitter Serial # _____

B Practitioner Information
Office Name: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
ESCO Center Number: _____
(Please call ESCO 800-992-3726 to obtain center number)

Practitioner, please transmit completed form to ESCO's claim FAX (**800-894-6056**). Once processed, ESCO will mail a response to you in addition to any destination indicated below:

C Practitioner Fax Machine _____
 Practitioner E-mail address _____

For ESCO Office Use only.

FM 4D L _____ D _____

Cov _____ Code _____

PH# _____

O5A URW ULW



3215 Fernbrook Lane N. • Plymouth, MN 55447-5325
FAX 800-894-6056 • e-mail: info@earserv.com
web site: http://www.earserv.com



Claim Procedure

Once ESCO has received, processed and approved a signed and complete claim form, the claim procedure is as outlined below.

1. **ESCO** will send an authorization number to the practitioner within one working day of approving the claim. (Practitioner: please remember to include your fax number or e-mail address on the claim form.)
2. The **practitioner** will order a replacement or repair from the manufacturer by placing the authorization number and ESCO's address in the BILL TO portion of the manufacturer's order form or repair form. The practitioner's address and information should be written in the SHIP TO portion of the manufacturer's form. All orders should be sent directly to the manufacturer. Please do NOT send hearing instruments to ESCO for repair. Hearing devices that are sent to ESCO will be refused and sent back to your office.
3. The **manufacturer** will ship the repair or replacement directly to the practitioner's office; the manufacturer will bill ESCO. Replacements will be made with the same make and model worn by the patient prior to the loss, damage or breakdown.

BTE & OTE/Open Fit Hearing Instruments

Follow the claim procedure outlined to the left to obtain a repaired or replaced BTE/OTE hearing instrument. Please note the earmold or external receiver are ONLY covered if the BTE/OTE hearing instrument is replaced. Loss, Damage or Repair of these parts are NOT covered as a separate claim. If an earmold is part of the BTE claim, order the earmold directly from the earmold company and send the earmold invoice to ESCO for reimbursement.

Contacting ESCO

To contact an ESCO customer service representative regarding a claim please use the numbers listed below:

ESCO Customer Service800-992-3726

ESCO Toll Free Claim FAX800-894-6056



Manufacturer Phone Numbers

Advanced Bionics.....	800-678-2575	Micro-Tech.....	800-745-4327
America Hears.....	800-785-6052	Neuromonics.....	800-606-3876
Amplisound.....	800-835-2001	Nu-Ear.....	800-626-8327
Audibel.....	800-769-2590	Omni.....	800-527-0872
Audifon.....	800-776-0222	Oticon.....	800-526-3921
Audina.....	800-223-7700	Phonak.....	800-777-7333
Audio D/Finetone.....	800-532-3984	Phonic Ear.....	800-227-0735
AudioSync.....	877-278-8482	Prairie Labs.....	800-322-8238
Bernafon.....	888-941-4200	Rexton.....	800-876-1141
Beltone.....	800-621-1275	SeboTek.....	800-388-9041
Cochlear.....	800-523-5798	Siemens.....	800-766-4500
Electone.....	800-432-7483	Sonic Innovations.....	888-423-7834
General Hearing Instruments (GHI).....	800-824-3021	Sonovation.....	800-462-8336
GN ReSound.....	800-248-4327	Starkey.....	800-328-8602
Interton/AHS.....	800-247-4741	Unitron Hearing.....	800-888-8882
Janus Development.....	252-551-9042	Widex.....	800-221-0188
Magnatone.....	800-327-5159	Williams Sound.....	800-328-6190
MED-EL.....	888-633-3524		