



# 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 your loss or damage. **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 and below right) that are essential to processing your claim.

**1** Wearer Name \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_  
(If applicable)  
Mailing Address \_\_\_\_\_  
City/Province/  
Postal Code \_\_\_\_\_  
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)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

For ESCO Office Use only.



## Hearing Instrument Information

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

Policy # \_\_\_\_\_

Please supply the information regarding each claimed device:

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

**B** Practitioner Information  
Office Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/Province/  
Postal Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
ESCO Center Number: \_\_\_\_\_  
(Please call ESCO 866-662-0206 to obtain center 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 above.

**5** Wearer Signature \_\_\_\_\_  
(Or patient representative) Date

**C** Practitioner Signature \_\_\_\_\_  
Date

Practitioner, please transmit completed form to ESCO's claim FAX (450-264-3081). Once processed, ESCO will send an authorization letter to you at the destination indicated below:

**D**  Practitioner Fax Machine \_\_\_\_\_  
 Practitioner E-mail address \_\_\_\_\_  
 Mail to practitioner address shown above.



# 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 or damage.

## BTE Hearing Instruments

Follow the claim procedure outlined to the left to obtain a repaired or replaced BTE hearing instrument. 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. Please note, the earmold is covered only if it is part of a BTE hearing instrument claim. It is NOT covered as a separate claim. Loss or damage of the earmold only is NOT covered.

## Contacting ESCO

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

**ESCO Customer Service ..... 866-662-0206**  
**ESCO FAX ..... 450-264-3081**