ESCO EAR SERVICE COMPANY Claim Form

An incomplete claim form will delay your claim.

Complete the below information. Ask your hearing care provider to complete the hearing device section. Send this claim form to ESCO **within 90 days of the occurrence**. Both the policyholder and the hearing care providers signatures are required before ESCO can process your claim. Once this form has been processed, ESCO will send a letter regarding the status of your claim to you, the policyholder at the mailing address shown below, and to the practitioner.

Policy Holder/Claim Information

Hearing aid wearer (or the parent/guardian), complete the below information. Pay particular attention to numbered items below that are essential to processing your claim.

1 Wearer Name _____

Guardian Name _____
(If applicable)

Mailing Address _____

City/State/Zip _____

Phone Number _____

2 Date of occurrence _____
(Specific month/day/year required)

3 The reason for your claim (select one)

☐ Loss (Describe the events surrounding the loss)

_____

_____

_____

☐ Damage Repair/Service Repair
(Describe the malfunction–for example, component failure.)

_____

_____

_____

☐ Damage Beyond Repair
(Describe the unintentional events surrounding the damage.)

_____

_____

_____

Sworn Statement Signatures

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

4 Wearer Signature _____
(Or guardian) Date

Hearing Device Information

The information below is to be completed by the hearing care provider. Areas marked by arrows A - C (below) are essential to processing this claim. Please see reverse for additional claim procedure information.

Policy # _____

Please supply the information regarding each claimed device:

Specifics	☐ Right Ear	☐ Left
A Serial #		
Model		
Manufacturer		

Style (Check the appropriate box.)

☐ BTE ☐ RIC ☐ ITC ☐ HS
☐ ITE ☐ CIC ☐ MC ☐ Other _____

❑ Remote /Transmitter Serial # _____

B Hearing Care Provider Information

Office Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

❑ Provider fax Machine _____

❑ Provider E-mail address _____

Please transmit completed form to ESCO's claim FAX (800-894-6056). Once processed, ESCO will mail a response. Claims can be monitored at www.ESCO.com/pro/dashboard. In addition, practitioners may request information sent via Fax or E-mail (check box above).

C Practitioner Signature _____
Date

For ESCO Office Use only.

☐ 4D L _____ D _____

Cov _____ Code _____

PH# _____

3215 Fernbrook Lane N • Plymouth, MN 55447
1-800-992-3726 • FAX 800-894-6056
info@ESCO.com • www.ESCO.com

Claim Procedure

Download enterable PDF claim form: Scan this code with your Smartphone

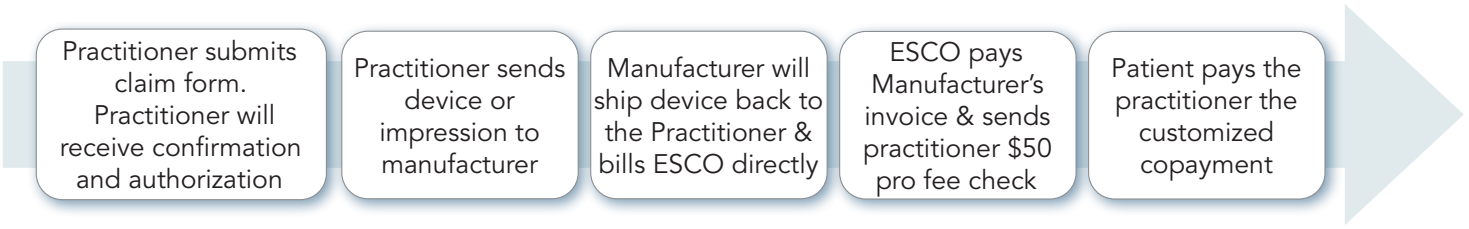
HOW TO SUBMIT A CLAIM

CLAIMS MUST BE SUBMITTED BY THE PRACTITIONER:

Submit a claim online, by fax, or by email.

Claim forms are available online at **www.ESCO.com,** by emailing ESCO at **info@ESCO.com** or by calling **1-800-992-3726**.

CLAIM REGISTRATION PROCESS



ONLINE CLAIM REGISTRATION:

- Sign in to your ESCO Pro Portal Dashboard at www.ESCO.com/pro. Click on "PRO SITE LOGIN".
- Once on your dashboard, select "Policies".
- Search for your patient, or select the patient from the list of policyholders.
- Click on the "Claims" button on the right-hand side.
- Follow the on-screen claim form instructions (details of the claims, date of occurrence, etc...)
- Click the "Submit Claim" button to complete the claim submission.

A confirmation email will be sent to the email associated with the user placing the claim. ESCO will contact you once the claim is received and processed. You can also find your claims at the bottom of the main dashboard. Please allow 1-2 business days for processing of the claim approval or denial.

ESCO's authorization will include a bill-to and PO number.

All orders for replacement or repair should be sent directly to the manufacturer.

MAIL A CLAIM REGISTRATION

- **MAIL** completed and signed claim form to:
  ESCO
  3215 Fernbrook Lane N
  Plymouth, MN 55447

- **EMAIL** completed and signed claim form to:
  info@ESCO.com

- **FAX** completed and signed claim form to:
  1-800-894-6056