New Jersey
Hearing-aid reimbursement form

Member identification number_________________________________

Member name____

Member date of birth___________ **Date of service**______________

Please circle your coverage: **CMM** **HMO** **HMO PLUS** **POS PLUS**

PPO **POS** **POS WITH REFERRAL**

Please indicate the name and address of the hearing-aid provider:

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Mail this form and your receipt to:

AmeriHealth New Jersey
P.O. Box 41574
Philadelphia, PA 19101-1574

In order to receive your reimbursement, you must include your paid receipt. Please contact our Customer Service Department at 1-800-275-2583 if you have any questions regarding this benefit. Thank you.

AmeriHealth HMO, Inc. QCC Insurance Company d/b/a AmeriHealth Insurance Company