

SERVICE REQUEST FORM (ALL FIELDS ARE REQUIRED)

TODAY'S DATE: _____

CLAIMANT NAME: _____

CLAIMANT PHONE: _____ **SSN:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMPLOYER (even if retired): _____ **CLAIM#:** _____

HEARPO PROVIDER: _____

FAX: _____ **PHONE:** _____

REPAIR INFORMATION:

LEFT

RIGHT

Manufacturer & Model: _____

Please circle technology type: Basic Programmable Digital

Serial Number: _____

Date of Fit: _____

Service Needed: _____

Cost of Service: _____

Reason: _____

HEARING TEST REQUESTED: (Check box if requesting audiogram/92557):

Reason for request: _____

BATTERIES: (Check box if batteries are being requested)

MISCELLANEOUS: (Please provide description/reason for request)

Please fax this request back to HearPO at 763-268-4210 to process this request!