KCK FIREFIGHTER'S RELIEF ASSOCIATION
HEARING AID REIMBURSEMENT CLAIM FORM

(ATTACH COPIES OF PAID RECIEPTS)

THE KCK FIREFIGHTER'S RELIEF ASSOCIATION WILL REIMBURSE UP TO $500 EVERY 24 MONTHS FOR DURABLE MEDICAL GOODS THAT ARE NECESSARY AS A RESULT OF SERVICE CONNECTED INJURIES FOR ACTIVE MEMBERS.

CLAIMS SHOULD BE SENT TO:

EMAIL: KCKFRACLAIMS@GMAIL.COM
FAX: 913-904-0857
KCKFRA, 10940 PARALLEL PKWY, STE. K, BOX 308
KANSAS CITY, KS 66109
QUESTIONS: NATHANIEL SCHOTANUS (913) 523-5818

NAME_____PHONE_____
ADDRESS_____
CITY, STATE_____ZIP_____

PHYSICIAN'S STATEMENT

_____IS AN ACTIVE FIRE FIGHTER AND HAS BEEN REQUIRED TO WORK IN CONDITIONS AND ATMOSPHERES THAT CAUSE HEARING LOSS. THERE IS NO SINGLE EPISODE OF INJURY, HOWEVER, REPEATED EXPOSURE TO LOUD NOISES (SUCH AS SIRENS AND ENGINE NOISE) HAVE CULMINATED IN THIS PATIENT'S NEED FOR HEARING AIDS. THIS CONDITION SHOULD BE CONSIDERED TO BE SERVICE CONNECTED.

PHYSICIAN'S NAME_____

ADDRESS_____

PHYSICIAN'S SIGNATURE_____DATE_____

AUTHORIZATION

I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY, INSURANCE COMPANY OR OTHER ORGANIZATION, INSTITUTION OR PERSON, THAT HAS ANY RECORDS OR KNOWLEDGE OF MY HEALTH CONCERNING HEARING LOSS TO GIVE TO THE KANSAS CITY, KANSAS FIREFIGHTER'S RELIEF ASSOCIATION, OR IT'S REPRESENTATIVES, ANY SUCH INFORMATION.

CLAIMANT'S SIGNATURE_____DATE_____

(FOR OFFICE USE ONLY)

DATE OF LAST REIMBURSEMENT FOR DURABLE MEDICAL GOODS:_____
AMOUNT OF REIMBURSEMENTS WITHIN PAST 24 MONTHS:_____
TOTAL OUT OF POCKET – THIS CLAIM:_____
TOTAL APPROVED REIMBURSEMENT:_____
OFFICERS SIGNATURE_____DATE:_____