150 S. Fifth St., Suite 2300
Minneapolis, MN 55402
1-888-319-9206

WORKERS' COMPENSATION REFERRAL REQUEST FORM

Please complete form and fax to 651-925-0219 or email to WorkComp@amplifon.com

CLAIMANT INFORMATION		
Name:	SSN:	DOB:
Address:	Claim #:	Jurisdiction State:
City:	State:	Zip:
Daytime Phone:	Evening Phone:	

REQUESTER INFORMATION		
Company Name:		
Requester Name:	Requester Email:	
Address:		
City:	State:	Zip:
Phone:	Employer:	

TPA / CARRIER INFORMATION *(if applicable)*		
TPA / Carrier Name:		
Contact Name:	Contact Email:	
Address:		
City:	State:	Zip:
Phone:		

PROVIDER / AUDIOLOGIST INFORMATION *(if applicable)*	
Provider Name:	Facility Name:
Address:	Phone:

REQUESTED SERVICES / DEVICES	
	Hearing Test
	Hearing Aids ☐ New ☐ Replacement
	Clean & Check
	Wax Filters
	Repair
	Programming
	Other (please describe)

ATTACHED *(check all that apply)*	
	Medical Report(s)
	Current Audiogram
	Hearing Loss Approval Letter