Replacement Claim Form

This form must accompany all Loss & Damage/Hearing Loss Claims with current order forms.

Please complete the following information:

Bill to:

Account: CF668424
Health Services, LLC
1059 E. Iron Eagle Dr, Ste 175
Eagle, ID 83616-6855

Ship to:

Account: CF668424
Miracle-Ear Klamath Falls
905 Main St #205
Klamath Falls, OR 97601

Customer Information

Name: _____

Address: _____

_____

Phone: _____

Left Serial Number: _____ **Right Serial Number:** _____

Warranty Expiration: _____

- Hearing Loss Claim– Miracle-Ear Digitally Programmable Product Only: Please attach original audiogram and current audiogram.
- Loss or Damage Claim– Damaged aids must be enclosed. If lost aids are found, they must be turned in to your Miracle-Ear center. Please attach original and current audiogram.

Circumstances: _____

_____

Customer Signature: _____ **Date:** _____

Consultant Signature: _____ **Date:** _____

Notary Signature: _____ **Date:** _____

Notary Stamp:

Account Number: _____ **Internal Use Only:** _____

Signature of Approval: _____

**Added options or services may incur additional charges*