

# 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:** CF668420  
Health Services, LLC  
1059 E. Iron Eagle Dr, Ste 175  
Eagle, ID 83616-6855

**Ship to:**

**Account:** CF668420  
Miracle-Ear Grants Pass  
953 SE 7th St  
Grants Pass, OR 97526

**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*