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: CF668401
Health Services, LLC
1059 E. Iron Eagle Dr, Ste 175
Eagle, ID 83616-6855

Ship to:

Account: CF668401
Miracle-Ear Vancouver
8101 NE Parkway Dr, Ste G2
Vancouver, WA 98662

Customer Information

Name: _____

Address: _____

_____

Phone: _____

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

Warranty Expiration: _____

- Hearing Loss Claim– Miracle-Ear Digitally Programmable Product Only
- 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:** _____

Acknowledgement of Individual **STATE OF WASHINGTON COUNTY OF Clark**

On this day personally appeared before me _____, to me known to be the individual(s) described in and who executed the within and foregoing instrument, and acknowledge that he/she/they signed the same as his/her/ their free and voluntary act deed, for the uses and purposes therein mentioned.

Given under my hand and seal of office this _____ day of _____, 20 _____.

Notary Public residing at _____ **Notary Stamp:**

Printed Name: _____

My Commission Expires: _____