Cochlear speech processor replacement



Please ask your GP or Specialist to complete this form if you've received a cochlear speech processor replacement outside of a hospital. To check your eligibility for this benefit before completing the form please call us on 134 246.

1 Patient's details Pleas	se use black pen ar	and print in UI	PPERCASE									
Member number	Title	Fir	st names									
Surname										Date of b	irth	
2 GP/Specialist details												
GP/Specialist's name												
Address												
Suburb									State		Postcod	le
Phone	Mo	lobile phone				Pros	theses Li	st Code				
3 Declaration by GP/Sp	ecialist											
I confirm that the provision of this		ocessor replac	ement is m	edically ne	cessary,	that the	prosthes	is is includ	ded on the	Department	of Heal	th
and Ageing Prosthesis List as at t	he date of service an	nd that the pro	cessor beir	ng replaced	l is not w	vithin wa	rranty.					
GP/Specialist signature												
										Date:	/	/
4 Declaration by Memb	er/Guardian											
I declare that the information of												
practitioner and if benefits have												
this claim, or for purposes relate providers, and received by the p												
speech processor replacement in		is isini. I datilo	noe anni to	contact til	o prostir	6313 3up	oner or II	icaicai pro	actioner ii	in relation to	tire pay	ment of the
Member/Guardian signature												
										Date:	/	/

Submitting your form

Log in to your account at **ahm.com.au**, go to the **Upload documents** section and upload this form under the **Cochlear Speech Processor Replacement form** option.

You can also post to ahm health insurance Locked Bag 4, Wetherill Park NSW 2164.