DEPARTMENT OF HEALTH

PRESCRIPTION HEARING AID CONSUMER COMPLAINT FORM

PENNSYLVANIA DEPARTMENT OF HEALTH-HEARING AID PROGRAM

MAIL TO : 2525 North Seventh Street, Suite 210D
Harrisburg, PA 17110
717-787-4779 Fax 717-231-4790 Email: ra-ddc@pa.gov

PLEASE NOTE: COMPLAINTS MAY ALSO BE FILED (using a different form) WITH THE OFFICE OF ATTORNEY GENERAL (OAG) BUREAU OF CONSUMER PROTECTION-HEALTHCARE UNIT-
EMAIL healthcare@attorneygeneral.gov PHONE 717-705-6938.
OAG COMPLAINT FORMS ARE AVAILABLE AT www.attorneygeneral.gov

DATE of COMPLAINT SUBMITTED: _____

COMPLAINANT INFORMATION:		**COMPLAINT AGAINST**:
Patient Name:		**Business Name**
Address:		**Address:**
City, State, Zip:		**City, State, Zip:**
Phone		**Fitter/Aud/MD Name:**
If Filed By Person other than Patient/Purchaser		
Name:		**Fitter Registration # (if known)**
Relationship to Patient		**Dealer Registration# (if known)**
Phone:		**Business Phone**

PURCHASE INFORMATION:

DATE OF PURCHASE/SALE: _____ # of HEARING AID(s) BOUGHT: _____
TOTAL PURCHASE PRICE: $_____ DEPOSIT/AMT. PAID $_____
PAYMENT METHOD (circle one): Check Credit Card_____ Other: _____
DATE OF DELIVERY(if applicable): _____
DATE of CANCELLATION (if applicable): _____ DATE OF RETURN (if applicable): _____
WHERE SALE OCCURRED (circle one): Personal Residence Office Other:_____

PAPERWORK/DOCUMENTATION:

Under State Law certain documentation must be provided, explained, and in some cases signed by consumer prior to the sale of any prescription hearing aid in Pennsylvania.
Please answer the following to the best of your ability
on paperwork received on Page 2 of this form and if available attach copy.

PAPERWORK/DOCUMENTATION:

1.Did you review and sign a one page DISCLOSURE AGREEMENT that outlined all services and goods, and amount of monies refundable or nonrefundable should the hearing aids be returned or sale cancelled? _____ (if yes, please attach copy)

2. Did you review and sign a MEDICAL WAIVER or seek a physician signed medical referral? _____ (if yes, please attach copy)

3. Did you review and sign a PURCHASE RECEIPT outlining the make, model, serial number of the hearing aid selected and your rights on filing a complaint? _____ (if yes, please attach copy)

4. If IN HOME SALE, did you receive information on how to cancel within 3 business days? _____ (if yes, please attach copy)

5. Did you receive a WARRANTY on the hearing aids? _____ If so, for how long_____

7. Do you recall undergoing certain tests and evaluation prior to sale? _____

Please briefly describe:

_____

_____

8. Have you filed a complaint with any other agency or business ____If so, with whom?_____

PROVIDE ADDITIONAL DETAILS AND OVERVIEW OF YOUR COMPLAINT:

You may use additional paper if necessary

DETAILS OF COMPLAINT:

MAKE SURE TO ATTACH COPIES of ALL RELEVANT PAPERWORK.

Please include any additional information you may feel is relevant..

_____

_____

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_____ _____

SIGNATURE **DATE**

OFFICE USE Only DATE of COMPLAINT received : _____

DATE