CLAIM FOR LOCAL 29 DIRECT OPTICAL REIMBURSEMENT

VISION SCREENING, 1919 Middle Country Rd., Suite 304, Centereach, NY 11720

PLEASE READ CAREFULLY: This is a yearly Optical benefit which will reimburse you up to $250.00. This will cover services for your Eye Exam, Glasses or Lenses whichever you choose.

Please make sure to print all of your information clearly and sign this form where indicated. Mail this claim form to the above address and attach an original copy of your receipt from your Vision Provider and you will be reimbursed directly from Vision Screening. Always keep a copy for your records.

TO BE COMPLETED BY ELIGIBLE MEMBER

NAME AND HOME ADDRESS (Please Print) LAST	FIRST	MIDDLE INIT.	S.S.# LAST 4 DIGITS		DATE OF BIRTH Mo. / Day / Yr.
				❑ MALE ❑ FEMALE	

NUMBER	STREET	CITY	STATE	ZIP CODE	MARITAL STATUS:
					❑ SINGLE ❑ DIVORCED ❑ MARRIED ❑ WIDOWED

PATIENT INFORMATION: (COMPLETE ONLY IF PATIENT IS A DEPENDENT) NAME OF DEPENDENT			DATE OF BIRTH Mo./Day/Yr.	MARITAL STATUS:
	❑ SPOUSE ❑ CHILD	❑ MALE ❑ FEMALE		❑ SINGLE ❑ DIVORCED ❑ MARRIED ❑ WIDOWED

TO BE COMPLETED BY PROVIDER

SERVICES:
Please complete the requested and applicable information:

TYPE OF SERVICE	PLEASE CHECK	CHARGES
Eye Examination	❑	$
Frames	❑	$
Single Vision Lenses	❑	$
Bifocal Lenses	❑	$
Trifocal Lenses	❑	$
Progressive Lenses	❑	$
Contact Lenses	❑	$
Cataract Single Vision Lenses over +8.00	❑	$
Cataract Bifocal Lenses over +8.00	❑	$
Cataract Contact Lenses	❑	$
TOTAL		$

EXAMINER

Name ____________________

Address ____________________

Tele. No. ____________________

Date of Services ____________________

DISPENSER

Name ____________________

Address ____________________

Tele. No. ____________________

Date of Services ____________________

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FOR OFFICE USE ONLY • DO NOT WRITE HERE

Claim No. ________ Amount ________ Claim Examiner ________ Date ________

Authorization to release information - I hereby authorize any Provider, Insurer or other Organization to release any information regarding the history, treatment, or benefits payable for this claim to the Plan Administer or its authorized agent for the purpose of determining benefits payable.

X ____________________ SIGNED (PATIENT OR PARENT IF MINOR) ________ DATE

ALL CLAIM CHECKS WILL BE DISBURSED TO MEMBERS ONLY

CERTIFICATION - I certify that the foregoing information is true and correct.

X ____________________ SIGNED (PATIENT OR PARENT IF MINOR) ________ DATE

Rev 03/14