CLAIM FOR PLUMBERS LOCAL NO. 1 WELFARE FUND

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

PLEASE READ CAREFULLY: 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 **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 | ❑ MALE ❑ FEMALE | DATE OF BIRTH Mo. Day Yr.

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

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

Tax ID _____

DISPENSER

Name_____

Address _____

Tele. No. _____

Date of Services_____

Tax ID _____

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 04/17