TEAMSTERS #261 & EMPLOYERS WELFARE FUND
351 Northgate Circle Suite B, New Castle, PA 16105
(724) 652-4667

CLAIM FOR VISION CARE BENEFITS

PART A – PATIENT & INSURED INFORMATION – TO BE COMPLETED BY MEMBER:

PATIENT NAME:

PATIENT DATE OF BIRTH: ___/___/___

EMPLOYEE NAME:

PATIENT ADDRESS:
_____
_____

PATIENT SEX:
( ) M ( ) F

EMPLOYEE'S SOCIAL SECURITY NUMBER:
_____/_____/_____

PATIENT RELATIONSHIP TO INSURED:
( ) SELF ( ) SPOUSE ( ) CHILD ( ) OTHER

EMPLOYEE'S EMPLOYER:

DOES PATIENT HAVE ANY OTHER VISION COVERAGE, IF SO ENTER POLICY HOLDER AND PLAN NAME:
_____
_____

INSURED'S PHONE :
( ) _____- _____

EMPLOYEES ADDRESS IF DIFFERENT FROM PATIENT:
_____
_____

*****DUE TO AUDITING PURPOSES ALL VISION CLAIM FORMS MUST HAVE AN ITEMIZED RECEIPT ATTACHED TO THE ORIGINAL CLAIM FORM OR THEY WILL BE RETURNED*****

PART B – PHYSICIAN OR OPTOMETRIST INFORMATION – TO BE COMPLETED BY PHYSICIAN/OPTOMETRIST/SUPPLIER

EYE EXAMINATION – DATE OF SERVICE: _____ $ _____
CONTACT LENS EXAMINATION – DATE OF SERVICE_____ $ _____
***EXAMINER'S SIGNATURE** _____ **ADDRESS**_____
PHONE_____ **ID# OR SSN#** _____
LENSES ( ) SINGLE VISION ( ) BIFOCAL ( ) TRIFOCAL $ _____
FRAMES $ _____
PHOTOGRAY $ _____
MISCELLANEOUS LENS ADD ONS $ _____
_____ $ _____
_____ $ _____
CONTACT LENS $ _____
SUNGLASSES (EMPLOYEE BENEFIT ONLY) $ _____
***SUPPLIERS NAME** _____ **ADDRESS** _____
PHONE _____ **ID# OR SSN#**_____
TOTAL COST $ _____

PART C – TO BE COMPLETED BY PATIENT OR PARENT IF MINOR: I AUTHORIZE ANY INDIVIDUAL OR ORGANIZATION TO RELEASE ANY INFORMATION TO TEAMSTERS #261 & EMPLOYERS WELFARE FUND FOR ANY VISION TREATMENT, OBSERVATION, SERVICE OR BENEFITS RECEIVED OR PAYABLE TO ME ON MY BEHALF.

_____
SIGNATURE OF PATIENT (OR PARENT IF A MINOR)

PART D – TO BE COMPLETED BY PARTICIPANT MEMBER:

_____ _____
MEMBER SIGNATURE DATE

PLEASE NOTE: ORGINAL CLAIM FORMS MUST BE SUBMITTED TO PROCESS. FAXED CLAIMS WILL NOT BE PROCESSED.

VISION ALLOWANCES ON BACK OF THIS FORM

FOR FUND USE ONLY	CLAIM NUMBER	AMOUNT PAID	PROCESSED BY	DATE