UFCW Local 1459 and Contributing Employers Health & Welfare Fund

33 Eastland Street
Springfield, MA 01109-2348
(413) 733-0177 or Toll Free 1-800-634-2700

VISION CLAIM FORM

INSTRUCTIONS FOR MAKING A CLAIM FOR BENEFITS:

1. **Answer all required questions on this side of form, and sign the bottom section.**
2. **If you want us to pay the provider of services directly, sign the "Assignment of Benefits" section on the reverse side.**
3. **Have the provider of services complete the "Physician or Supplier" section or attach an original itemized bill. The bill must include the patient's name, provider's name, date of service, and an itemized breakdown of exam and materials charges.**
4. **If you are making a claim for more than one provider of service, submit a separate form for EACH provider.**

EMPLOYEE INFORMATION

Employee Name (First, Middle, Last)	**Plan No.** **K119**	Social Security Number
Home Address City State Zip	Date of Birth	Daytime Phone Number
	Marital Status [ ] Single [ ] Divorced [ ] Married [ ] Widowed	Work Status [ ] Active [ ] Disabled [ ] Retired [ ] Other (specify)

PATIENT INFORMATION		**SPOUSE INFORMATION**	
Patient Name (First, Middle, Last)	Date of Birth	Spouse's Name (First, Middle, Last)	Spouse's Date of Birth
Relationship to Employee [ ] Self [ ] Spouse [ ] Child [ ] Other(specify)	Sex [ ] Male [ ] Female	Spouse's Social Security Number	Employment Status [ ] Active [ ] Retired [ ] Not Employed
*Is Child Married? [ ]Yes [ ] No Full-time student? [ ] Yes [ ] No Are natural parents divorced or separated? [ ] Yes [ ] No Does natural parent WITHOUT custody have financial responsibility for health expenses? [ ] Yes [ ] No		Spouse's Employer Name and Address	

OTHER VISION INSURANCE (Complete the following section if you or any member of your family is covered by any other Vision plan.)

Name of Person Covered by Other Insurance (First, Middle, Last)		Name and Address of Insurance Company
Relationship to You of Person Covered by Other Insurance [ ] Self [ ] Patient [ ] Spouse [ ] Other: specify relationship		
Policy or Plan No.	Ins. ID Number	Type of Coverage [ ] Individual [ ] Family

ANY PERSON, WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

AUTHORIZATION FOR RELEASE OF INFORMATION

I/We authorize the release to the UFCW Local 1459 and Contributing Employers Health & Welfare Fund and its agents of any evidence or information about me or my dependents that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original.

Employee's Signature Date

Patient's Signature (if patient is legal adult) Date

PLEASE SUBMIT SEPARATE FORMS FOR EACH PHYSICIAN OR SUPPLIER

This form is for reporting claims payable under a Routine Vision Benefit, which usually covers only the following (subject to certain limitations):

1. **Routine eye examinations** for determining general eye health and evaluating visual function, including prescription for correction of visual problems; and
2. **Pairs of eyeglass lenses** or contact lenses prescribed as a result of such an examination, and **eyeglass frames.**

ASSIGNMENT OF BENEFITS	I authorize payment of benefits to the undersigned physician or supplier for the services described below. Employee's Signature Date

PHYSICIAN OR SUPPLIER INFORMATION **(This section to be completed by a physician or supplier unless the claim is submitted with an itemized bill that includes a breakdown of exam and materials charges.)**		
Patient's Name (Print in full)		
Patient's Date of Birth	Sex [ ] Male [ ] Female	Patient's Relationship to Employee

Quantity	**Description of Services or Materials**	**DATE OF SERVICE (For lenses, use date ordered)**	**CHARGES (Less any discount)**
	Routine Eye Exam		
	Frames		
	Single Vision Lenses		
	Bifocal Lenses		
	Trifocal Lenses		
	Lenticular Lenses		
	Hard or Soft Contact Lenses		
	Disposable Contact Lenses		
	Other (Please Describe):		

Physician or Supplier's Name and Address (print)	Patient's Account Number	Total Charges
	Physician or Supplier's Tax ID Number	Amount Paid
	WE WILL NOT ACCEPT ASSIGNMENT WITHOUT PHYSICIAN OR SUPPLIER'S TAX IDENTIFICATION NUMBER	Balance Due
Physician or Supplier's Telephone Number ( ) -	Physician or Supplier's Signature Date	