VISION CARE PROGRAM
CLAIM FORM

Sheet Metal Workers' Local #83 Insurance Fund
718 Third Street, Albany, NY 12206-2007
518-489-1377

Please type or print – Include all information indicated – submit original receipts.

MEMBER INFORMATION

Patient Name (First, Middle, Last): ______________________________

Member Name: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Social Security Number: ______________ Telephone Number: ______________

Patient's Date of Birth: ______________ Relationship to Member: ______________

ADDITIONAL COVERAGE

Do you or your spouse have other vision insurance? ( ) yes ( ) no
check one

If you checked yes, please complete the following:

Coverage provided through:

Name of Employer: ______________________________

Name of other coverage (Insurance Company Name): ______________________________

Address: ______________________________

Telephone Number: ______________

Individual covered ( ) self ( ) spouse ( ) dependents

Name of Individual with other coverage (Member or Spouse): ______________________________

Social Security Number: ______________

Is patient a full time student at college? ( ) yes ( ) no Year in school? ______Name of School ______________
Address ______________

Complete all sections and sign the claim form.

2. Attach a copy of bills for vision care services covered under this plan. Charges should be itemized (exam, lenses and frames or contacts). If your other coverage is primary also attach their explanation of benefits showing their payment.

3. Bills should include the name of the patient, provider name, date of service, type of service and charges.

4. Submit the claim to the Fund Office.

All information furnished hereon is true and correct to the best of my knowledge. I hereby authorize any provider of services to furnish the Fund with any information required to correctly process this claim.

____
Member's Signature Date