

**VISION CARE FORM**

**TEAMSTERS HEALTH AND WELFARE FUND**  
 6981 NORTH PARK DRIVE SUITE 400  
 PENNSAUKEN, NJ 08109

IN ORDER TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLY WITH THE FUND'S ELIGIBILITY REGULATIONS AND MUST BE AT LEAST TWO YEARS FROM LAST USING THIS BENEFIT.

THIS FORM DOES NOT GUARANTEE PAYMENT

PLEASE CALL FUND OFFICE TO VERIFY 2 YEAR LIMIT AND ELIGIBILITY

CLAIM NUMBER

**PATIENT INFORMATION TO BE COMPLETED AND SIGNED BY MEMBER**

1. PATIENT'S NAME (First name, middle name, last name)	2. A. PATIENT'S DATE OF BIRTH	2. B. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3. MEMBER'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. MEMBER'S EMPLOYER		6. MEMBER'S SOCIAL SECURITY NO.
			MEMBER'S LOCAL NO.

WAS VISION CARE REQUIRED BECAUSE OF INJURY?

YES  NO IF YES, COMPLETE QUESTIONS BELOW

WAS INJURY CAUSED BY WORK?

YES  NO HAVE YOU FILED A CLAIM FOR THE DISABILITY WITH WORKMAN'S COMPENSATION?  YES  NO

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE MY DOCTOR OR ANY INDIVIDUAL OR ORGANIZATION TO RELEASE AND DISCLOSE ALL FACTS CONCERNING THIS VISION TREATMENT.

MEMBERS SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**TO BE COMPLETED BY DOCTOR**

HAS PATIENT WORN GLASSES BEFORE THIS EXAMINATION?  YES  NO PRESCRIPTION?  YES  NO

IF REPLACEMENT, INDICATE CHANGE IN DIOPTRER AND DEGREE OF AXIS FROM PREVIOUS PRESCRIPTION. \_\_\_\_\_

HAS CATARACT SURGERY BEEN PERFORMED?

YES  NO PATIENT'S NAME \_\_\_\_\_

IF YES, GIVE DATE OF SURGERY: \_\_\_\_\_

**PLEASE COMPLETE ONLY AFTER FITTING OF APPLIANCES**

INDICATE CHARGES FOR THE FOLLOWING SERVICES AND MATERIALS

FUND USE ONLY

EXAMINATION: DATE: \_\_\_\_\_

\$	
\$	
\$	
\$	TOTAL COSTS TO PATIENT

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LENS:  SINGLE  BIFOCAL  TRIFOCAL  
 LENTICULAR  GLASS  PLASTIC

FRAMES: \_\_\_\_\_  
 (American Made Only)

AN ITEMIZED BILL FOR THE ABOVE MUST BE ATTACHED TO THIS CLAIM FORM

SIGNATURE BY THE DOCTOR CERTIFIES THAT ALL SERVICE LISTED ABOVE HAVE BEEN COMPLETED

INDIVIDUAL PRACTITIONERS SOC. SEC. No.

DOCTORS SIGNATURE: \_\_\_\_\_ DTE: \_\_\_\_\_

TAX I.D. NUMBER

TYPE OR PRINT DOCTORS NAME \_\_\_\_\_ DEGREE \_\_\_\_\_

LICENSE NUMBER

PHONE NUMBER: \_\_\_\_\_ ADDRESS \_\_\_\_\_

PARTICIPATING DOCTOR  YES  NO CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**AUTHORIZATION TO PAY DOCTOR**

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO: (NAME OF DOCTOR) \_\_\_\_\_

VISION CARE BENEFITS OTHERWISE PAYABLE TO ME UNDER MY VISION CARE PLAN, BUT NOT TO EXCEED THE ELIGIBLE CHARGES DECLARED ON THIS FORM.

I UNDERSTAND I AM FINANCIALLY LIABLE TO THE DOCTOR FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION.

MEMBERS SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_