VISION CARE FORM

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

CLAIM NUMBER

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

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 ☐ MALE ☐ 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 DIOPTER 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: _____	$		
LENS: ☐ SINGLE ☐ BIFOCAL ☐ TRIFOCAL ☐ LENTICULAR ☐ GLASS ☐ PLASTIC	$		
FRAMES: _____ (American Made Only)	$		
TOTAL COSTS TO PATIENT	$		

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 _____