VISION CLAIM FORM

SEND TO: NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN
P.O. BOX 476
NEWTOWN SQUARE, PA 19073-0476
1-800-CLAIM11 OR 1-800-252-4611

PLAN MEMBER:
1. Complete the applicable items and signatures in Part 1.
2. Have the Examiner complete (or attach fully itemized statement) and sign Part 2.
3. Have the Dispenser complete (or attach fully itemized statement) and sign Part 3.

PART 1: TO BE COMPLETED BY PLAN MEMBER

1. PATIENT NAME (First, Middle, Last)	2. RELATIONSHIP TO MEMBER SELF / SPOUSE / CHILD / OTHER	3. SEX M / F	4. PATIENT BIRTHDATE MO. / DAY / YEAR	5. IF FULL TIME STUDENT SCHOOL / CITY

6. MEMBER NAME FIRST / MIDDLE / LAST	7. MEMBER SOCIAL SECURITY NO.	MEMBER DATE OF BIRTH MONTH / DAY / YEAR

8. MEMBER MAILING ADDRESS	9. NAME OF YOUR EMPLOYER IN THE ELEVATOR INDUSTRY
CITY, STATE, ZIP	10. LOCAL UNION NUMBER / MEMBER PHONE NO. AREA CODE / NUMBER

11. / 12. FOR ADMINISTRATIVE USE ONLY	13. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO NAME / SOCIAL SECURITY NO. If yes, indicate	14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13

15. IS PATIENT COVERED BY ANOTHER VISION PLAN? ☐ YES ☐ NO	IF YES, SPOUSE'S DATE OF BIRTH MONTH / DAY / YEAR	GROUP NO.	NAME AND ADDRESS OF CARRIER

16. IF CLAIM IS DUE TO ACCIDENT, INDICATE DATE, TIME, PLACE AND HOW ACCIDENT OCCURRED.	DID ACCIDENT OCCUR AT WORK? ☐ YES ☐ NO

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I ALSO HEREBY AUTHORIZE THE UNDERSIGNED EXAMINER/DISPENSER TO RELEASE ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT OR PARENT IF MINOR) _____ DATE _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED
EXAMINER ☐ YES ☐ NO DISPENSER ☐ YES ☐ NO
OF THE VISION CARE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (MEMBER) _____ DATE _____

PART 2: TO BE COMPLETED BY EXAMINER

17. EXAMINER NAME	22. DATE OF EXAMINATION
18. MAILING ADDRESS	PROFESSIONAL SERVICES / AMOUNT
CITY, STATE, ZIP	23. EXAMINATION (CPT Code _____)
19. SOC. SEC. OR T.I.N. / 20. STATE LICENSE NO. / 21. PHONE NO. (WITH AREA CODE)	24. OTHER (Specify _____)
	25. SALES TAX (IF ANY)

26. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSES? ☐ YES ☐ NO	27. HAS CATARACT SURGERY BEEN PERFORMED? ☐ YES ☐ NO	28. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? ☐ YES ☐ NO	29. TOTAL

30. TYPE OF LENSES PRESCRIBED
☐ NONE ☐ SINGLE ☐ BIFOCAL ☐ TRIFOCAL ☐ LENTICULAR ☐ CONTACT ☐ OTHER, Specify:

I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.

EXAMINER SIGNATURE _____ DATE _____

EXAMINER TITLE ☐ OPHTHALMOLOGIST ☐ OPTOMETRIST

PART 3: TO BE COMPLETED BY DISPENSER

31. DISPENSER NAME	36. DATE MATERIAL ORDERED
32. MAILING ADDRESS	PROFESSIONAL SERVICES / AMOUNT
CITY, STATE, ZIP	37. LENS(ES) ☐ GLASS ☐ PLASTIC ☐ SAFETY ☐ PAIR ☐ 1/2 PAIR
33. SOC. SEC. OR T.I.N. / 34. STATE LICENSE NO. / 35. PHONE NO. (WITH AREA CODE)	38. FRAME ☐ REGULAR ☐ SAFETY
	39. SALES TAX (IF ANY)

40. TYPE OF LENSES DISPENSED ☐ SINGLE ☐ BIFOCAL ☐ TRIFOCAL ☐ LENTICULAR ☐ CONTACT ☐ OTHER, Specify:	41. TOTAL

42. IF BIFOCAL OR TRIFOCAL LENSES DISPENSED, INDICATE: ☐ FY ☐ EXEC ☐ KRYPTOK	43. FRAME MODEL OR CAT. NO	44. FRAME MFR. NAME

I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.

DISPENSER SIGNATURE _____ DATE _____

DISPENSER TITLE ☐ OPTOMETRIST ☐ OPHTHALMOLOGIST ☐ OPTICIAN

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.