RETURN FULLY COMPLETED FORM TO:

FOR OFFICE USE ONLY:
Effective Date ______
Date Certified ______
Verified By ______
Inside ______ Driver ______

Local 734 Welfare Fund

6643 North Northwest Hwy. • Chicago, IL 60631-1360

FOR VISION CLAIM INFORMATION CALL: 773-594-2810

INSTRUCTIONS: This Claim Form is to furnish the information needed to Service Your **Vision** Expense Claim. **Please answer all questions fully and attach all appropriate itemized Bills.**

1. Name of Member ______ Social Security No. ______

2. Name of Patient ______ Date of Birth ______ Relationship to Member ______

3. Occupation ______ Where Employed, or School, if Student ______

4. Are the expenses for which this claim is filed covered by any other Group Vision Plan? ☐ Yes ☐ No

   If yes, give: ______
   (Name of Insurance Company or Organization)

   ______
   (Street Address) (City) (State) (Zip Code)

   ______
   (Policy No.) (Certificate No.) (Effective Date) (Name of Certificate Holder)

5. Is this expense the result of injury or disease arising out of or in the course of employment? ☐ Yes ☐ No

6. Reason for obtaining new lens and/or frames ______

Signature of Member

SIGNED X ______ DATE ______

ADDRESS ______
(Street) (City) (State) (Zip Code)

IMPORTANT: HAVE YOU SIGNED THIS FORM AND ARE ALL QUESTIONS ANSWERED?

VISION INSURANCE CLAIM FORM

VICF (75)

Physician and/or Supplier: After you have completed and signed this form, please return it to the Insured's Employer.

PART A—PATIENT & INSURED INFORMATION

1. PATIENT'S NAME (*First name, middle initial, last name*)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (*First name, middle initial, last name*)
4. PATIENT'S ADDRESS (*Street, city, state ZIP code*)
5. PATIENT'S SEX — MALE ☐ ☐ FEMALE
6. INSURED'S I.D. No. (*Include any letters*)
7. PATIENT'S RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S GROUP NO. (*Or Group Name*)
9. OTHER HEALTH INSURANCE COVERAGE—Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number
10. WAS CONTIONON RELATED TO
    A. PATIENT'S EMPLOYMENT — YES ☐ ☐ NO
    B. AN AUTO ACCIDENT — YES ☐ ☐ NO
11. INSURED'S ADDRESS (*Street, city, state, ZIP code*)

12. I hereby authorize the release of any information necessary to process this claim. ▶ Insured's or Authorized Person's signature — Date

13. I authorize payment of Vision Care benefits to undersigned Physician or Optometrist for services described below. ▶ Patient's or Authorized Person's signature — Date

PART B—EXAMINING PHYSICIAN OR OPTOMETRIST'S INFORMATION

14. Indicate Diagnosis or Nature of Disease, Injury or Vision Disorder
15. Type of vision care patient had prior to this examination
    ☐ Conventional Lenses ☐ Contacts ☐ Low Vision Aids
    ☐ Visual Training/Vision Therapy ☐ Medication
    State condition treated ______
    Surgery (explain) ______
16. Describe conditions diagnosed which require treatment at this time
17. Does Patient require a prescription change at this time?
    Frames ☐ Yes ☐ No Lenses ☐ Yes ☐ No
    If yes, why?
18. Indicate date of patient's last change of: lenses______ frames______
    Check the materials or treatment prescribed (note number prescribed): ☐ Frames______
    ☐ Single Vision______ ☐ Bifocal______ ☐ Trifocal______ ☐ Contact Lens______
    ☐ Low Vision Aid______ ☐ Visual Training/vision therapy______ ☐ Other______
19. If Contact Lenses, would the visual acuity be corrected to 20/70 in the better eye by use of Conventional Lenses?
    ☐ Yes ☐ No
20. If tinted lenses, photograys, sunglasses or conventional lenses are prescribed which are not impact resistant, state reason why
21. Report of services, or attach itemized bill. (If previous form submitted to this carrier, you need show only dates and services since last report.)

Date of Service	Services Rendered	Charges

22. Physician's or Optometrist's Name, Address, Zip Code, and Telephone No.
23. Social Security No.
24. Employer I.D. No.
25. Other Identifying No.
26. Total Charges
27. Amount Paid
28. Balance Due
29. Accept Assignment ☐ Yes ☐ No
30. Signature of Physician/Optometrist — Sign Here ▶
31. Date signed
32. Your Patient's Account No.

33. I hereby authorize payment of Vision Care benefits to the undersigned Supplier for services described below. ▶ Insured's or Authorized Person's Signature — Date

PART C—SUPPLIER INFORMATION (To be completed by Dispenser of Prescription other than Prescribing Physician)

34.	RX Number	Date of Delivery	Fee	Manufacturer's Trade Name	Style/Size/Width
Lenses					
Frames					
Contacts					
Other					

35. Supplier's Name, Address, Zip Code and Telephone No.
36. Employer I.D. No.
37. Other Identifying No.
38. Accept Assignment ☐ Yes ☐ No
39. Signature of Supplier — Sign Here ▶
40. Date Signed
41. Patient's Account No.

LOCAL 734