RESET FORM

LOCAL 734 WELFARE FUND
VISION CLAIM FORM

Submit via Mail or Fax Only

6643 N Northwest Hwy Chicago, IL 60631 | PH: 773-594-2810 | FAX: 773-631-3824

Part 1: To be completed by Member. Must include itemized receipt to be considered for reimbursement.

1. Patient's full name (first, middle initial, last)
2. Patient birthdate (MM/DD/YY) / /
3. Relationship to member ☐ Self ☐ Spouse ☐ Child ☐ Other
4. Sex ☐ M ☐ F
5. Member's full name (first, middle initial, last)
6. Member's identification number
7. Member's birthdate (MM/DD/YY) / /
8. Member's mailing address (street address or P.O. Box, City, State, ZIP)
9. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER
   Is patient a full-time student? ☐ Yes ☐ No
   If Yes, name and address of school:
10. Member's Phone No:
11. Member's Employer (company name)
12. Member's Email Address:

Questions 13 and 14 must be completed with each claim submission.

13. Is patient covered by another vision plan? ☐ Yes ☐ No
    Name and address of other carrier
    Policy number
    Name and address of other employer:
14. Other employee/subscriber name
    Employee/subscriber identification number
    Date of birth (MM/DD/YY) / /
    Relationship to patient

15. **I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of treatment. I certify these statements to be true and complete to the best of my knowledge.**

X _____ Signature (patient, or parent if minor) _____ Date

Check one box only:
16A. ☐ **Please send payment to me OR**
16B. ☐ **Please pay provider below**

X _____ Signature (insured person) _____ Date

Part 2: To be completed by Attending Provider.

IMPORTANT: If an itemized receipt is attached, DO NOT complete Part 2.

17. Vision care provider name and address

For Yes answers to questions 19-24, enter a brief description and dates.
19. Is treatment result of occupational illness or injury? ☐ Yes ☐ No
20. Is treatment result of auto accident? ☐ Yes ☐ No
21. Other accident? ☐ Yes ☐ No
22. This is a (please check one): ☐ Statement of actual services ☐ Pretreatment estimate
23. Is this for LASIK/PRK? ☐ Yes ☐ No
24. Date of Service | Exam | Materials

Specialty | Phone number

Email | Fax number

18. Federal Tax ID Number ☐ SSN ☐ TIN | NPI (National Provider Identifier)

License #

25. **Examination and Treatment Record** Please include date of service, description of services, procedure code and fee.

Service	CPT Code	Fee	Lenses	CPT Code	Fee	Options	CPT Code	Fee
LASIK/PRK left eye		$	Single		$	Anti-reflective		$
LASIK/PRK right eye		$	Bifocal		$	Scratch resist		$
Exam		$	Trifocal		$	Tint		$
Lens fitting		$	Progressive		$	Hi-index		$
Refraction		$	Lenticular		$	Edge polish		$
Other		$	Contacts		$	Other		$
Frames		$	Other		$	Discounts		

26. Remarks

27. Total $

28. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.

X _____ Signature (Provider) _____ Date

29. Address where treatment was performed