New York City Electrical Division Health & Welfare Fund

P.O. Box 479 • Fresh Meadows, NY 11365-0479 • PHONE: (718) 820-1690 •

☐ ACTIVE
☐ RETIRED

OFFICE USE ONLY

OPTICAL FORM

INSTRUCTIONS

Type or print ALL the information requested on this form and SIGN it below. Submit any ACTUAL bills or receipts for optical equipment purchases – MADE WITHIN THE PAST 120 DAYS ONLY – that are covered by this optical plan. Use only ONE [1] form per patient.

CLAIMS SUBMITTED FOR PURCHASES MADE PRIOR TO 120 DAYS WILL NOT BE PAID!

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 ☐ 7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8. INSURED'S I.D. No. *(Include any letters)* 6. 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 CONDITION RELATED TO PATIENT'S EMPLOYMENT 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.	Patient'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 at this time?
Frames ☐ Yes ☐ No Lenses ☐ Yes ☐ No If yes, why?

18. Indicate care of patient's last change of lenses _____ frames _____
Check the materials or treatment prescribed (note number prescribed) ☐ Frames _____
☐ Simple 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.	26. Total Charges
	24. Employer I.D. No.	27. Amount Paid
	25. Other Identifying No.	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	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.

RETURN COMPLETED FORM TO: *New York City Electrical Division Health & Welfare Fund P.O. Box 479 • Fresh Meadows, New York 11365-0479*