

VISION CLAIM FORM

INSTRUCTIONS:

1. Employee should complete Part 1.
 2. Physician should complete Part 2.
 3. Completed form should be mailed to Trusteed Plans Service Corporation, the claims administrator
- Part 1. To be completed and signed by employee (please print)

Claims Administrator:
 TRUSTEED PLANS SERVICE CORP.
 CLAIMS DEPARTMENT
 P.O. BOX 1894
 TACOMA, WA 98401-1894
 (206) 564-5611 (800) 426-9786 X210

LAST NAME		FIRST NAME		INITIAL	BIRTHDATE	SOCIAL SECURITY NO.	
ADDRESS <input type="checkbox"/> Check if new address				CITY		STATE	ZIP
TELEPHONE NUMBER		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE		CLAIM IS MADE FOR <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	
NAME OF EMPLOYER		GROUP #	PERSON RECEIVING VISION CARE <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH OF PERSON RECEIVING VISION CARE		
NAME OF PERSON RECEIVING VISION CARE					DOES CLAIMANT HAVE OTHER VISION BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR VISION CARE (INCLUDING DEPENDENT INSURANCE)							
WAS VISION CARE REQUIRED BECAUSE OF AN INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES, COMPLETE BELOW			
WAS INJURY CAUSED BY YOUR WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>		HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKER'S COMPENSATION CARRIER? YES <input type="checkbox"/> NO <input type="checkbox"/>			IS VISION EXAMINATION REQUIRED AS A CONDITION OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		
The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize my doctor to furnish and disclose all facts concerning this disability. Date _____ Signature _____					I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. SIGNED (Insured or Authorized Person)		

Part 2. To Be Completed by Doctor

PHYSICIAN NAME, ADDRESS, CITY, STATE, ZIP (M.D., O.D. OR DISPENSING OPTICIAN)		TELEPHONE NUMBER
PHYSICIAN IRS TAX NUMER	PHYSICIAN SIGNATURE	DATE

HAS PATIENT WORN GLASSES BEFORE THIS EXAMINATION? _____ YES NO TYPE _____

IF YES, STATE REASON FOR REPLACEMENT _____

IF YOU PRESCRIBED GLASSES, CHECK TYPE: SINGLE VISION BIFOCAL TRIFOCAL OTHER (DESCRIBE) _____

HAS CATARACT SURGERY BEEN PERFORMED? YES NO DATE _____

CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? YES NO

ARE EXISTING FRAMES BEING USED FOR THE NEW GLASSES? YES NO IF NO, WHY NOT? _____

PROFESSIONAL SERVICES	CPT	DATE	CHARGE	PROFESSIONAL SERVICES	CPT	DATE	CHARGE
VISION SURVEY				CONTACTS, EACH LENS			
VISUAL EXAME W/O TONOM				FRAME SERVICE			
VISUAL EXAME W/ TONOM				OTHER			
SINGLE VISION LENSES				OTHER			
BIFOCAL LENSES							
TRIFOCAL LENSES							
LENTICULAR LENSES							