Return completed form to:

I.A.T.S.E. Local #16 Health & Welfare Trust Fund
4160 Dublin Boulevard, Suite 400 • Dublin, California 94568-7756
Telephone (925) 833-7300 • Toll Free 1-800-833-6696

VISION CLAIM FORM

TO BE COMPLETED BY SUBSCRIBER

1. PATIENT'S NAME (Last name, first name, middle initial)

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME (Last name, first name, middle initial)

4. PATIENT'S ADDRESS (Street, City, State, Zip Code)

5. PATIENT'S SEX — MALE ☐ ☐ FEMALE

6. INSURED'S SOC. SEC. NO. or UNIQUE ID NO.

7. PATIENT'S RELATIONSHIP TO INSURED — 1. SELF ☐ 4. SPOUSE'S ☐ 5. CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. (Or Group Name) | INSURED'S DATE OF BIRTH

9. OTHER HEALTH INSURANCE COVERAGE — Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

Does patient have other health insurance? ☐ YES ☐ NO

Other Carrier Amount Paid

10. WAS CONDITION RELATED TO:
A. Patient's Employment? ☐ Yes ☐ No
B. An illness? ☐ Yes ☐ No
Date of Illness ____/____/____
C. An Accident? ☐ Yes ☐ No
Date of Accident ____/____/____

Have you filed a claim with anyone else for this injury? ☐ YES ☐ NO

If yes, indicate name

11. INSURED'S EMPLOYER NAME

12. INSURED'S ADDRESS (Street, City, State, Zip Code)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE ***(Read before signing)*** — I authorize the release of any medical information necessary to process this claim and request payment benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. I authorize payment of medical benefits to undersigned physician or supplier, for service described below.

SIGNED *(Insured or Authorized Person)*

TO BE COMPLETED BY PROVIDER

14. DATE OF: ◀ ILLNESS (FIRST SYMPTOM)

15. NAME OF REFERRING PHYSICIAN

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

17. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
1.
2.

18. GLASSES PRESCRIBED. CHECK TYPE:
SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐
TINT PRESCRIBED? ☐ YES ☐ NO

20. HAS CATARACT SURGERY BEEN PERFORMED? ☐ YES ☐ NO DATE

19. PROVIDER'S PRESCRIPTION

	SPHERE	CYLINDER	AXIS	PRISM	BASE
R. E.	*	*			
L. E.	*	*			
READING ADDITION		R. E.	+ *	L. E.	+ *

21. DATE OF SERVICE	PROCEDURE CODE		22. CHARGES
	V5400	Eye Exam by M.D.	
	V5413	Eye Exam by O.D.	
	V5415	Single Lenses With or Without Frames	
	V5416	Bifocal Lenses With or Without Frames	
	V5417	Trifocal Lenses With or Without Frames	
	V5418	Lenticular Monofocal Lenses With or Without Frames	
	V5419	Lenticular Multi-Focal Lenses With or Without Frames	
	V5430	Contact Lenses — Hard One Lens	
	V5431	Contact Lenses — Soft One Lens	
	V5432	Contact Lenses — Hard Two Lenses	
	V5433	Contact Lenses — Soft Two Lenses	
	V5435	Contact Lenses — Hard Postsurgery One Lens	
	OTHER	DESCRIPTION	

21. DATE OF SERVICE	PROCEDURE CODE		22. CHARGES
	V5436	Contact Lenses — Soft Postsurgery One Lens	
	V5437	Contact Lenses — Hard Postsurgery Two Lenses	
	V5438	Contact Lenses — Soft Postsurgery Two Lenses	
	V5439	Intraocular Lens	
	V5440	Frames/Parts	
	V5441	Shatter Proofing/ Specially Ground Lens	
	V5442	Anti-Reflective Coating	
	V5443	Photogreys	
	V5444	Tints Less than #3	
	V5445	Tints More Than #2	
	V5446	Spare Pair of Glasses	
	V5447	Repair of Glasses	
27.		TOTAL CHARGES $	

23. SIGNATURE OF PHYSICIAN OR SUPPLIER

SIGNED DATE

26. PROVIDER LICENSE NO.

28. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS and ZIP CODE

S.S.# or EMPLOYER ID #

24. PATIENT'S ACCOUNT NO.

25. PROVIDER PHONE NO.

1M 5/11

® 73
Zablocki Printing Co.