



Return completed form to:

I.A.T.S.E. Local #16 Health & Welfare Trust Fund

P.O. Box 2300, Livermore, California 94551-2300
 Telephone (925) 449-7070 • 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 <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. INSURED'S SOC. SEC. NO. or MEDICARE NO. (Include any letters)	
		7. PATIENT'S RELATIONSHIP TO INSURED 1. SELF <input type="checkbox"/> 4. SPOUSE'S <input type="checkbox"/> 5. CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		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? <input type="checkbox"/> YES <input type="checkbox"/> NO Other Carrier Amount Paid		10. WAS CONDITION RELATED TO: A. Patient's Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No B. An illness? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Illness ____/____/____ C. An Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident ____/____/____ Have you filed a claim with anyone else for this injury? <input type="checkbox"/> YES <input type="checkbox"/> 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 (<i>Read before signing</i>) — 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 (<i>Insured or Authorized Person</i>) _____	

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? <input type="checkbox"/> YES <input type="checkbox"/> NO																					
17. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY 1. _____ 2. _____		18. GLASSES PRESCRIBED. CHECK TYPE: SINGLE VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> TINT PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO		19. PROVIDER'S PRESCRIPTION																					
				<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>SPHERE</th> <th>CYLINDER</th> <th>AXIS</th> <th>PRISM</th> <th>BASE</th> </tr> <tr> <td>R. E. *</td> <td>*</td> <td></td> <td></td> <td></td> </tr> <tr> <td>L. E. *</td> <td>*</td> <td></td> <td></td> <td></td> </tr> <tr> <td>READING ADDITION</td> <td>R. E.</td> <td>+ *</td> <td>L. E.</td> <td>+ *</td> </tr> </table>		SPHERE	CYLINDER	AXIS	PRISM	BASE	R. E. *	*				L. E. *	*				READING ADDITION	R. E.	+ *	L. E.	+ *
SPHERE	CYLINDER	AXIS	PRISM	BASE																					
R. E. *	*																								
L. E. *	*																								
READING ADDITION	R. E.	+ *	L. E.	+ *																					
20. HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE _____																									
21. DATE OF SERVICE		22. CHARGES		21. DATE OF SERVICE																					
PROCEDURE CODE		PROCEDURE CODE		22. CHARGES																					
V5400 Eye Exam by M.D.		V5436 Contact Lenses — Soft Postsurgery One Lens																							
V5413 Eye Exam by O.D.		V5437 Contact Lenses — Hard Postsurgery Two Lenses																							
V5415 Single Lenses With or Without Frames		V5438 Contact Lenses — Soft Postsurgery Two Lenses																							
V5416 Bifocal Lenses With or Without Frames		V5439 Intraocular Lens																							
V5417 Trifocal Lenses With or Without Frames		V5440 Frames/Parts																							
V5418 Lenticular Monofocal Lenses With or Without Frames		V5441 Shatter Proofing/ Specially Ground Lens																							
V5419 Lenticular Multi-Focal Lenses With or Without Frames		V5442 Anti-Reflective Coating																							
V5430 Contact Lenses — Hard One Lens		V5443 Photogreys																							
V5431 Contact Lenses — Soft One Lens		V5444 Tints Less than #3																							
V5432 Contact Lenses — Hard Two Lenses		V5445 Tints More Than #2																							
V5433 Contact Lenses — Soft Two Lenses		V5446 Spare Pair of Glasses																							
V5435 Contact Lenses — Hard Postsurgery One Lens		V5447 Repair of Glasses																							
OTHER DESCRIPTION				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.																							