VISION

Statement of Claim

RETURN FORM TO:

IBEW-NECA SOUTHWESTERN HEALTH BENEFIT FUND
4040 McEWEN, SUITE 100
DALLAS, TEXAS 75244-5092 (972) 980-1123 Metro (972) 263-8185

PART I

EMPLOYEE NAME		SOCIAL SECURITY NO.
EMPLOYEE MAILING ADDRESS	LOCAL UNION NUMBER	EMPLOYER
CITY STATE ZIP		

PATIENT NAME	PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT BIRTHDATE MO. / DAY / YEAR	FULL TIME STUDENT? YES____ NO____ IF YES, NAME OF ED. INSTITUTION:

TODAY'S DATE _____ EMPLOYEE'S SIGNATURE _____

PART II

Check One

IS THIS CLAIM FOR:

- ☐ NEW LENSES
- ☐ REPLACEMENT LENSES
- ☐ CONTACTS (cosmetic)
- ☐ CONTACTS (medically necessary)

(IF YES, DIAGNOSIS NEED) _____

DOCTOR'S STATEMENT (List Charges)

DIAGNOSIS:
FOR MEDICAL _____
CONTACTS _____

DEFINITION OF MEDICALLY NECESSARY CONTACTS

MEDICALLY NECESSARY DEFINITION IS AS FOLLOWS:
"CONTACT LENSES ARE CONSIDERED COSMETIC LENSES UNLESS THEY ARE FOR USE AFTER CATARACT SURGERY OR UNLESS THE VISUAL ACUITY OF THE INSURED CAN BE CORRECTED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONTACT LENSES BUT NOT WITH CONVENTIONAL LENSES."

TYPE OF LENS (check one)

- ☐ SINGLE VISION Rx
- ☐ BI-FOCAL Rx
- ☐ TRI-FOCAL Rx
- ☐ LENTICULAR Rx
- ☐ CONTACTS

CHARGES

Exam: $_____
Lenses: $_____
Frames: $_____
TOTAL: $_____

If Lens and Frames purchased other than from doctors — Name and Address of Company purchased from _____

(PLEASE ATTACH PAID RECEIPTS TO CLAIM FORM)

DATE EXAMINATION PERFORMED: ____/____/____ (Month / Day / Year)

DOCTOR'S NAME _____ (please print)

ADDRESS _____

TELEPHONE NUMBER _____

- ☐ OPTHALMOLOGIST
- ☐ OPTOMETRIST
- ☐ OPTICIAN

INDIVIDUAL PRACTITIONER'S SOCIAL SECURITY NO. OR EMPLOYER IDENTIFICATION NO. | | | | | | | | | |

TODAY'S DATE _____, 20____ DOCTOR'S SIGNATURE _____

(DO NOT WRITE BELOW THIS LINE)

FOR ADMINISTRATION USE ONLY

DATE PAID ____/____/____ AMOUNT PAID $_____ CHECK NO._____

NEXT ALLOWABLE VISION BENEFITS:

EXAMS:_____ LENS:_____ FRAMES:_____

	Charges	Allow Benefit
Exam:	$_____	$_____
Lenses:	$_____	$_____
Frames:	$_____	$_____
TOTAL:	$	$

HOW TO FILE A CLAIM

For Vision Benefits

(1) Obtain a claim form from the Fund Office or any Local Union Office.

(2) Fill out and sign the claim form and have the doctor complete his portion.

(3) Attach all paid bills relating to the claim and be sure they are itemized. Incomplete forms and unclear bills may delay your payment.

(4) Mail the completed form along with the paid bills to the IBEW Claims Office addressed on the front side of this form.