VISION CLAIM FORM

PLEASE PRINT ALL INFORMATION BELOW CLEARLY FOR PROMPT PROCESSING OF YOUR CLAIM.

MAIL TO: **Vision Plan**
Pennsylvania Faculty Health & Welfare Fund
P.O. Box 60430
Harrisburg, Pennsylvania 17106-0430
Telephone: (717) 233-4776

PART I – TO BE COMPLETED BY MEMBER/EMPLOYEE

PARTS I & II must be completed in full

1. Employee Name (First, Middle, Last)		2. Member Date of Birth Mo. Day Year	3. Sex M F	4. University where member is employed.
5. Patient Name	6. Relationship to Employee Self Spouse Child Other	7. Patient Date of Birth Mo. Day Year	8. Sex M F	9. Full time Student School: City:
10. Employee Mailing Address		11. Spouse Date of Birth Mo. Day Year	12. Sex M F	13. Company where Spouse is employed.
14. City, State, Zip		15. Member Telephone Number:		
16. Is patient covered by another Vision Plan? ❑ Yes ❑ No If yes, Vision Plan name		17. Name and Address of Insurance Carrier		

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any vision plan, vision provider, insurance company, employer or insuring organization to release any information regarding the medical or vision history, treatment or benefits payable for this claim for the purpose of validating and determining benefits payable in connection with this claim. This authorization or photostatic copy of the original shall be valid for one year from the date of signature.
I understand that data may be extracted and transmitted to the Plan Administrator for statistical, audit, and verification purposes.

X_____ SIGNED (PATIENT OR PARENT IF MINOR) _____ DATE

PART II – TO BE COMPLETED BY ATTENDING VISION PROVIDER–Reimbursements are paid to Members only.

18. Vision Provider Name	21. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
19. Mailing Address	22. Is treatment result of auto accident? Other accident?			
20. City, State, Zip	23. Are these services covered by another plan?			If yes, name of other plan

24. DESCRIPTION OF SERVICES – Vision services requiring preauthorization must be submitted to the Fund Office before services are performed.	Date service Performed Mo. Day year	FEE Charged	For Fund Use Only
Faculty and Dependent Benefits			
Vision Examination and Related Tests			
Frames			
Lenses – Single Vision – Specify diopter change			
Bifocal – Specify diopter change			
Trifocal – Specify diopter change			
Contact Lenses – Single Vision – REQUIRED to specify diopter change			
Multifocal – REQUIRED to specify diopter change			
Faculty Only Benefits (please circle if completed):			
Sunglasses – Photogray – Transition Lenses			
Frames for Faculty Only Benefits (for above services)			
Reading Glasses Frames and Lenses			
The following services require preauthorization by the Fund Office*			
Aphakic Lenses			
Low Vision Aids			
Medically Required Contacts			
Keratoconus			
Cataracts			
Traumatic Eye Injuries			
* Need must be certified in a separate letter by an eye-care provider and submitted to the Fund Office before services are provided.			

I hereby certify that the procedures as indicated by date have been completed

TOTAL FEE CHARGED

25. _____ Date

SIGNED (Vision Provider)

REV. 1/2010