

FOX VALLEY LABORERS HEALTH AND WELFARE FUND

2400 BIG TIMBER ROAD, BUILDING B, SUITE 206, ELGIN, ILLINOIS 60124-7812

(847) 742-0900

VISION CLAIM FORM



SECTION I - MEMBER'S STATEMENT and PATIENT INFORMATION

1. MEMBER'S NAME	FIRST	MIDDLE INITIAL	LAST	2. Social Security Number _____								
3. Mailing Address, Street, City, State, Zip Code				4. Local Union Number _____		Single		Married		Divorced		
				Tel. No. () _____								
5. Patient Name: First Middle Initial Last			6. Relationship To Emp. Self Spse Dtr. Son		7. Sex M F		8. Patient Birth Date Mo. Day Yr.		9. Full time student <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Handicapped Child <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. OTHER HEALTH INSURANCE COVERAGE — Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number				12. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO				13. DATE OF ACCIDENT _____ PLACE OF ACCIDENT _____ DESCRIPTION OF ACCIDENT _____				
15. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF MEDICAL TREATMENT.						16. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED SERVICE PROVIDER; THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.						
SIGNED PATIENT or PARENT IF MINOR. _____ DATE _____						MEMBER'S SIGNATURE _____ DATE _____						

SECTION II - ATTENDING PHYSICIAN'S STATEMENT

17. IF CONTACT LENSES ARE BEING PRESCRIBED, PLEASE COMPLETE:

IS THIS THE FIRST PAIR FOLLOWING CATARACT SURGERY? _____ YES _____ NO

HAS PATIENT PREVIOUSLY HAD GLASSES? _____ YES _____ NO _____ DATE

HAS PATIENT PREVIOUSLY HAD LENSES? _____ YES _____ NO _____ DATE

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DC CODE

A DATE OF SERVICE	B* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE CPT-4	D DIAGNOSIS ICD9CM	F CHARGES
		COMPLETE EXAMINATION, INCLUDING EYE REFRACTION		
		COMPLETE EXAMINATION, EXCLUDING EYE REFRACTION		
		SINGLE VISION LENSES		
		BIFOCAL VISION LENSES		
		TRIFOCAL VISION LENSES		
		CONTACT LENSES		
		FRAMES		
		OTHER (Please Describe)		

18. PHYSICIAN'S SIGNATURE _____	20. TOTAL CHARGES _____	21. AMOUNT PAID _____	22. BALANCE _____
DATE _____	25. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. _____		
23. YOUR PATIENT'S ACCOUNT NO. _____	24. YOUR EMPLOYER ID. NO. _____		

INSTRUCTIONS FOR MEMBER

Please be sure that you complete ALL of the information in Section I on the front of this form.

NOTE:

- BOX 11 - If you or the patient is covered by any other group insurance policy, please provide us with the name of the insurance company, address and policy number(s).
- BOX 12 - Please be sure to check either yes or no to parts A and B.
- BOX 13 - If the patient's treatment is the result of an accident, please provide us with the date of the accident, place of the accident and a description of the accident.
- BOX 15 - Please be sure to sign this box for the release of any information.
- BOX 16 - Only sign this box if you want benefits paid directly to the provider. Do not sign this box if you want benefits paid to you.