

RETURN TO:
 SIDS
 Department 28-O
 PO Box 9005
 Lynbrook, NY 11563
 (516) 396-5544 / (718) 204-7172
 www.asonet.com

PORT CHESTER TEACHERS ASSOCIATION

WELFARE TRUST FUND

OPTICAL FORM

All claims must have a separate Rx in order to be processed

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name	Birth date	Relationship to Member Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Full Time College Student Yes <input type="checkbox"/> No <input type="checkbox"/>	School
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MEMBER/EMPLOYEE INFORMATION

Member Name	Birth date	Last 4 Digits of Social Security#
Street Address	City	State Zip Telephone# ()
Member's School or Work Location	Work Telephone#	

SPOUSE INFORMATION

Spouse's Name (Print)	Birth date	Social Security #	Is spouse covered by another Benefits Plan? YES <input type="checkbox"/> NO <input type="checkbox"/>
Name, Address, Telephone # of Spouses Employer			Name of Benefit Plan
ARE ANY OTHER OPTICAL BENEFITS AVAILABLE FOR THIS PATIENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		IS THIS AN HMO PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>	

PROVIDER INFORMATION (EXAMINER)

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#
Street Address	City	State	Zip Code
IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes <input type="checkbox"/> No <input type="checkbox"/> Occupational Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Certification of Examiner: I have examined the above named patient and have found the following vision defects: Signature of Examiner _____ Date _____			Fee(\$)

PROVIDER INFORMATION (DISPENSER OF FRAMES AND LENSES) *In order to process claim, please send separate Rx with claim form*****

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#
Street Address	City	State	Zip Code
IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes <input type="checkbox"/> No <input type="checkbox"/> Occupational Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>			
SERVICE	FEE(\$)	DATE	FOR OFFICE USE
FRAMES			
LENSES Single Vision			
Bifocal			
Trifocal			
Lenticular			
Subnormal			
Contact Lenses			

Signature of Dispenser _____ DATE _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Port Chester Teachers Association Welfare Trust Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

Signed (Patient, or Parent if Minor) _____ DATE _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment of the benefits (otherwise payable to me) directly to the above named physician. I understand I am financially responsible for charges not covered by this authorization.

Signed (Member) _____ DATE _____