GREENBURGH TEACHERS FEDERATION W.F.
C/O THE PREFERRED GROUP
P.O. BOX 15136 ALBANY, NY 12212-5136
(866) 989-8997 FAX (518) 641-0325

VISION CLAIM FORM

EMPLOYEE COMPLETE SHADED SECTIONS

1. EMPLOYEE'S NAME		2. SOCIAL SECURITY NO.	
3. EMPLOYEE'S MAILING ADDRESS (CITY)		(STATE or PROVINCE)	(ZIP CODE)
4. PATIENT NAME (IF A DEPENDENT)	5. RELATIONSHIP to EMPLOYEE	6. BIRTH DATE MO. DA. YR.	7. TEL.NO.

5. DOES PATIENT HAVE O\THER HEALTH COVERAGE? YES ☐ NO ☐
IF YES, PLEASE IDENTIFY

SERVICE PROVIDED

Eye Examination, Including Refraction $_____

Other (describe) _____

PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Add For Reading
Right					
Left					

Did the patient have glasses prior to your examination? YES ☐ NO ☐

If Yes, is prescription for new lenses different from that of lenses being replaced? YES ☐ NO ☐

DATE OF THIS EXAMINATION _____

SIGNED _____ DEGREE _____ DATE _____

ADDRESS _____ PHONE _____

Provider T.I.N. # _____

TO BE COMPLETED BY PROVIDER OF MATERIALS **Lenses For One Eye ☐** **Both Eyes ☐**

MATERIALS PROVIDED

Single Vision $ _____ Bifocal $ _____ Trifocal $ _____ Contact $ _____ Sunglasses $ _____ Other $ _____

If contact lenses prescribed, give reason _____

_____

Describe and indicate charges for special features such as hardening, tinting, plastic lenses, etc.— indicate seperately from lens charge.

_____

_____ $ _____

Frames

All Plastic, standard weight, style and hinges _____ $ _____

Combination metal and plastic _____ $ _____

All metal _____ $ _____

Other, describe _____ $ _____

Other materials, describe _____ $ _____

Are existing frames being used for the new lenses? YES ☐ NO ☐

If no, give reason _____

_____

SIGNED _____ DEGREE _____ DATE _____

ADDRESS _____ Provider T.I.N. # _____

*** If examining doctor provides glasses, only one signature is necessary.**

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

_____ DATE _____
SIGNED (PATIENT, OR PARENT IF MINOR)

Authorization to pay benefits to physician: I hereby authorize payment directly to the above physician for vision benefits otherwise payable to me for his/her services described on this form, but not to exceed the reasonable and customary fee for the service.

Signed _____