Steamfitters Local #449

BENEFIT FUNDS

c/o Frank M. Vaccaro & Associates, Inc.
1517 Woodruff Street
Pittsburgh, PA 15220-5305

Telephone: (412) 481-0300
Toll Free: (888) 355-5665
Fax: (412) 381-6132

VISION CLAIM FORM

Members Name________________________________ Soc.Sec.No.____________________________

Claim is for: _______Self _______Spouse ______Dependent Telephone No.:____________________

Name of Patient:______________________________ Date of Birth______________ Sex____________

Mailing Address:____

Signature of Insured:____ Date____________

Attending Physician's Statement

Patient's Name ____ Age __________

1. Has patient worn glasses before this examination? Yes No	2. Did you Prescribe glasses? Yes No	3. Single Vision Rx Tri-Focal Rx Bi-Focal Rx Lenticular	4. Can existing frame be used for new glasses? Yes No

Date of Services	Place of Services	Description of Services Rendered

Total Charges: $____________

Amount Paid: $____________

Balance Due: $____________

Ophthalmologist, Optometrist or Optician's Name			Federal ID No., If none, Social Security No.	
Date	Signature		Degree	Telephone
Street Address		City or Town	State	Zip

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payment to the above named Doctor

Date: ______________________ Signed: ____ (insured)

TO BE COMPLETED BY PROVIDER OF MATERIALS – MATERIALS

Date purchased glasses ____________________________

Lenses: $____________________________

Frame: $____________________________

Charges for glasses only

Total Charges: $____________

Amount Paid: $____________

Balance Due: $____________

Name and Address of Provider of Materials			Federal ID No., If none, Social Security No.	
Date	Signature		Degree	Telephone
Street Address		City or Town	State	Zip

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payment to the above named Doctor of the Benefits herein specified and otherwise payable to me but not to exceed the balance due of the Doctor's regular charges for this service. I understand I am financially responsible to the Doctor for charges not covered by this assignment. I hereby authorize the above named Doctor to release the information on this form.

Date: ______________________ Signed: ____ (insured)