RETURN TO:

Self-Insured Dental Services
Department 27-O
PO Box 9005
Lynbrook, NY 11563
(516) 396-5500 / (718) 204-7172

New Rochelle Federation of United School Employees Welfare Fund Optical Claim Form

Benefits available to one family member per calendar year

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name	Birth date	Relationship to Member	Full Time College Student	School
		Spouse ☐ Child ☐	Yes ☐ No ☐	

MEMBER/EMPLOYEE INFORMATION

Member Name	Birth date	Social Security#

Street Address	City	State	Zip	Telephone# ( )

Member's School or Work Location	Work Telephone#

PROVIDER INFORMATION (EXAMINER)

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#

StreetAddress	City	State	Zip Code

IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

Certification of Examiner: I have examined the above named patient and have found the following vision defects:

Exam Fee($)

Signature of Examiner _____ Date _____

PROVIDER INFORMATION (DISPENSER OF FRAMES AND LENSES)

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#

Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

WAS THE EXAMINATION REQUIRED BY: AN EMPLOYER AS A CONDITION OF EMPLOYMENT? Yes ☐ No ☐ BY A GOVERNMENT BODY? Yes ☐ No ☐

SERVICE	FEE($)	DATE	FOR OFFICE USE
FRAMES			
LENSES Single Vision			
Bifocal			
Trifocal			
CONTACT LENSES			
LASIK SURGERY			

Signature of Dispenser _____ **Date** _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the New Rochelle Federation of United School Employees Welfare Fund to release or receive 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 on 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 benefits directly to the above named Examiner, Optometrist or Optician ***(otherwise payable to me)*** *but not to exceed the charges shown. I understand that I am financially responsible to the provider for charges not covered by this authorization.*

Signature of Employee or Member_____ DATE _____