RETURN COMPLETED FORM TO:

OPTICAL CARE CLAIM FORM
INTERNATIONAL UNION OF OPERATING ENGINEERS WELFARE FUND OF EASTERN PENNSYLVANIA AND DELAWARE
POST OFFICE BOX 1627, FORT WASHINGTON, PENNSYLVANIA 19034

IMPORTANT: COMPLETE MEMBER SECTION IN FULL AND BE SURE TO SIGN MEMBER SIGNATURE SECTION.

TO BE COMPLETED BY MEMBER

1. Name: ______________________ Social Security No.: ______________
   Address: ______________________
   City: ______________ State: ______________ Zip Code: ______________
2. If claim is for Dependent, Name: ______________________
   Relationship: ______________ Date of Birth: ______________
3. Is patient covered by other optical plan: ______________________
   If YES, Name and Address of company providing benefits: ______________________
   ____
4. Is treatment the result of an accident? ______ Yes ______ No
   If YES, did injury arise out of employment? ______ Yes ______ No

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Welfare Fund or its representative, of any facts concerning the injury, illness, or treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original. I further certify that I was treated on the dates indicated below and received the prescriptions/services indicated.

☐ PLEASE PAY ALL BENEFITS TO ME DIRECTLY — Member Signature ______________

☐ PLEASE PAY ALL BENEFITS TO DOCTOR — Date ______________

TO BE COMPLETED BY DOCTOR

1. Name of Patient: ______________________
2. Date First Treated: ______________________
3. Vision Screening — Date ______________ Charge $ ______________
4. Vision Analysis — Date ______________ Charge $ ______________
5. Lenses:
   - Single Vision ______ Both ______ Right Only ______ Left Only ______
   - Bifocal ______
   - Trifocal ______ — Date Delivered ______________ Charge $ ______________
   - Lenticular ______
6. Frames ______ — Date Delivered ______________ Charge $ ______________
7. Other: (Please Describe Fully) ______________________
   ____

DATE ______________ TOTAL CHARGE $ ______________

Taxpayers Identification Number ______________

Provider's Name: ______________________
(PLEASE PRINT)

Provider's Address: ______________________
____

Provider's Signature: ______________________
(DEGREE)