FOX VALLEY LABORERS HEALTH AND WELFARE FUND

2371 Bowes Road, Suite 500, Elgin, Illinois 60123-5523
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VISION CLAIM FORM

SECTION I - MEMBER'S STATEMENT and PATIENT INFORMATION *(see reverse side for instructions)*

1. MEMBER'S NAME	FIRST	MIDDLE INITIAL	LAST
2. Social Security Number _____ – _____ – _____			
3. Mailing Address, Street, City, State, Zip Code			
4. Local Union Number _____			
	Tel. No. ( )	Single	Married / Divorced

5. Patient Name: First / Middle Initial / Last	6. Relationship To Emp. Self / Spse / Dtr. / Son	7. Sex M / F	8. Patient Birth Date Mo. / Day / Yr.	9. Full time student ☐ Yes ☐ No	10. Handicapped Child ☐ Yes ☐ No

11. OTHER HEALTH INSURANCE COVERAGE — Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	12. WAS CONDITION RELATED TO:	13. DATE OF ACCIDENT / PLACE OF ACCIDENT / DESCRIPTION OF ACCIDENT
	A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B. AN AUTO ACCIDENT ☐ YES ☐ NO	

15. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF MEDICAL TREATMENT.

▶ _____ SIGNED PATIENT or PARENT IF MINOR. _____ DATE

16. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED SERVICE PROVIDER; THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

▶ _____ MEMBER'S SIGNATURE _____ DATE

SECTION II - ATTENDING PHYSICIAN'S STATEMENT

17. IF CONTACT LENSES ARE BEING PRESCRIBED, PLEASE COMPLETE:

IS THIS THE FIRST PAIR FOLLOWING CATARACT SURGERY? _____ YES _____ NO

HAS PATIENT PREVIOUSLY HAD GLASSES? _____ YES _____ NO _____ DATE

HAS PATIENT PREVIOUSLY HAD LENSES? _____ YES _____ NO _____ DATE

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY — RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DC CODE

A DATE OF SERVICE	B* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE CPT-4	(EXPLAIN UNUSUAL SERVICE OR CIRCUMSTANCES)	D DIAGNOSIS ICD-10-CM	F CHARGES	G DAYS OR UNITS
			COMPLETE EXAMINATION, INCLUDING EYE REFRACTION			
			COMPLETE EXAMINATION, EXCLUDING EYE REFRACTION			
			SINGLE VISION LENSES			
			BIFOCAL VISION LENSES			
			TRIFOCAL VISION LENSES			
			CONTACT LENSES			
			FRAMES			
			OTHER (Please Describe)			

18. PHYSICIAN'S SIGNATURE		20. TOTAL CHARGES	21. AMOUNT PAID	22. BALANCE
▶ _____ DATE				
		25. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
23. YOUR PATIENT'S ACCOUNT NO.	24. YOUR PROVIDER ID. NO.			

INSTRUCTIONS FOR MEMBER

Please be sure that you complete ALL of the information in Section I on the front of this form.

NOTE:

BOX 11 - If you or the patient is covered by any other group insurance policy, please provide us with the name of the insurance company, address and policy number(s).

BOX 12 - Please be sure to check either yes or no to parts A and B.

BOX 13 - If the patient's treatment is the result of an accident, please provide us with the date of the accident, place of the accident and a description of the accident.

BOX 15 - Please be sure to sign this box for the release of any information.

BOX 16 - Only sign this box if you want benefits paid directly to the provider. Do not sign this box if you want benefits paid to you.