Vision Care Plan • Statement of Claim

ALL INFORMATION MUST BE COMPLETED ON THIS FORM

INSTRUCTIONS:

1. Employee completes Part 1 of this form.
2. Your optometrist, ophthalmologist, or optician completes Part 2 of this form.
3. A separate Claim Form is required for each family member.
4. One Claim Form is to be used for all services.
5. PLEASE ATTACH ALL ITEMIZED RECEIPTS TO THIS CLAIM FORM AND MAIL TO VBA AT THE ADDRESS LISTED BELOW WITHIN 180 DAYS FROM THE DATE OF SERVICE.

If you have any questions regarding the completion of this form, please contact your Personnel Office or Health & Welfare office.

PART 1 To be completed by Employee (please print or type)

EMPLOYEE'S FULL NAME (LAST, FIRST, MIDDLE)		SOCIAL SECURITY NUMBER	VBA CO# #652 Midwestern PA School EE Benefits Consortium
HOME ADDRESS		CITY STATE ZIP	
PATIENT'S FULL NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO EMPLOYEE SELF ☐ SPOUSE ☐ CHILD ☐	BIRTHDATE	

THIS CLAIM IS NOT FOR TREATMENT OF AN OCCUPATIONAL ACCIDENT AND I HEREBY AUTHORIZE ANY OF THE UNDERSIGNED TO DISCLOSE ANY NECESSARY INFORMATION TO THIS CLAIM I CERTIFY TO THESE STATEMENTS

MEMBER/EMPLOYEE SIGNATURE DATE

USE ONE FORM FOR EACH BENEFICIARY

PART 2 To be completed by optometrist, ophthalmologist or optician (please print or type)

EXAM

PRACTICE NAME — CIRCLE ONE: OD MD	PLEASE MARK THE SERVICE FOR THE TYPE OF EXAM PERFORMED: VISION ANALYSIS ☐ TONOMETRY ☐		
ADDRESS	DID YOU PRESCRIBE? YES ☐ NO ☐	DATE OF EXAM	EXAM CHARGE $
CITY STATE ZIP CODE	EXAMINING DOCTOR SIGNATURE DATE		
TELEPHONE NUMBER (INCLUDE AREA CODE)			

LENSES

DISPENSING PRACTICE NAME IF DIFFERENT FROM EXAMINING PRACTICE	DATE ORDERED	
ADDRESS	PLEASE INDICATE SEPARATE BASIC LENS CHARGE	
CITY STATE ZIP CODE	SINGLE VISION $_____	
TELEPHONE NUMBER (INCLUDE AREA CODE)	BIFOCAL $_____	
	TRIFOCAL $_____	
	LENTICULAR $_____	
DISPENSING DOCTOR/OPTICIAN SIGNATURE DATE	ELECTIVE CONTACTS $_____	
	MEDICAL REQ'D CONTACTS $_____	

FRAME

IF A NEW FRAME IS SUPPLIED, PLEASE INDICATE CHARGE

$_____

TOTAL CHARGE $_____

ATTACH YOUR RECEIPTS TO THIS CLAIM FORM AND MAIL TO:
VISION BENEFITS OF AMERICA
400 LYDIA STREET
CARNEGIE PA 15106