



Health and Welfare Fund
 6281 Youngstown-Warren Rd., Suite 240
 Niles, Ohio 44446
 330-652-3475
 Toll Free 800-362-9354

Vision Claim Form

(see Instructions on back)

USE A SEPARATE FORM FOR EACH PROVIDER

1. NAME OF INSURED FIRST MIDDLE LAST MAILING ADDRESS CITY, STATE, ZIP	2. SOCIAL SECURITY NO.	3. NAME OF PATIENT 5. SEX M F 6. PATIENT BIRTHDATE MO. DAY YEAR 7. IF FULL TIME STUDENT SCHOOL CITY	4. RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
9. IS PATIENT COVERED BY ANOTHER PLAN? PLAN NAME		GROUP NO.	

10. Any person who knowingly and with intent to defraud or deceive the Ohio Carpenters Health and Welfare Fund and files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime. I hereby certify that the information contained herein is true and correct. To all physicians and other health professionals, and all hospitals and other care institutions: You are authorized to provide Ohio Carpenters Health and Welfare Fund any information concerning health care, advise, treatment or supplies provided the Patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits. This authorization is valid for the eligibility period under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature

Date

11. Who do you want us to pay?...Pay me Pay the Provider

Your signature (required to pay provider)

12. Date Examined _____ 19____ Examination Charge \$ _____ Diagnosis _____

Reason for Examination Check one: _____ Accident _____ Illness _____ Routine _____

RX: O.D. _____ O.S. _____ ADD _____

Signature of Doctor _____ Tax Payer I.D. No. _____

Address _____
No. and Street City State Zip Code

(TO BE COMPLETED BY SUPPLIER OF EYEGLASSES)

13. Date of Purchase _____

Fitting Only _____	Charges \$ _____
Type of Lens Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/>	\$ _____
Type of Frame _____	\$ _____
Other (Explain) _____	\$ _____
Total	\$ _____

Optional Agency _____ Tax Payer I.D. Number _____

Address _____
No. and Street City State Zip Code

For Office Use Only

Social Security No. _____ / _____ / _____ Plan \$ _____ District _____

Date Eligible _____ / _____ / _____ Eligible Thru _____ / _____ / _____ Local _____

Name _____ / _____ / _____ Clerk _____

Insured _____ Dependent H _____ W _____ S _____ D _____ First Name _____ DOB _____ / _____ / _____

Date Incurred _____ / _____ / _____ Disability Code _____ / _____ Assigned Yes _____ No _____

Deductible \$ _____ Check Amount _____ / _____ / _____ Check Date _____ / _____ / _____

Check Number _____ Adjustor _____ / _____ / _____ / _____ Message _____

No.	Claim Description	From	Thru	Charge	Allowed
67	Eye Examination				
68	Lenses				
69	Contact Lenses				
70	Frames				
99					
99					
99	Not Covered			(-)	
99	Over Limit			(-)	(-)

CLAIM TOTALS

Keyer _____ / _____ / _____ / _____

CK AMT. _____

Deduct _____ Accumulations _____

Document # _____

YTD _____

Registration Number: _____

PLEASE REVIEW BEFORE SUBMITTING FORM

1. Complete items 1 – 11 on the reverse side of this form.
2. You can arrange for the Fund Office to make payment directly to the provider by signing the “Authorization To Pay Benefits To The Provider”. If you wish to be paid directly do not sign the Authorization. In either case, a statement of benefits paid will be sent to you.
3. Please have the provider complete items 12 & 13 and show services rendered.
4. The completed “Vision Form” should be submitted directly to:

**Ohio Carpenters Health and Welfare Fund
6281 Youngstown-Warren Road
Suite #240
Niles, Ohio 44446**

Telephone:
Toll free in Ohio 1-800-362-9354
Outside Ohio 1-330-652-3475

Vision Coverage is subject to specific limitations and exclusions. Please refer to your vision schedule of benefits for a description of covered services, percentage of fees payable, limitations and exclusions.