Steamfitters Local #449

BENEFIT FUNDS

c/o Frank M. Vaccaro & Associates, Inc.
1517 Woodruff Street
Pittsburgh, PA 15220-5305

Telephone: (412) 481-0300
Toll Free: (888) 355-5665
Fax: (412) 381-6132

VISION CLAIM FORM

Members Name______________________________ Soc.Sec.No.______________________________

Claim is for: _______Self _______Spouse _____Dependent Telephone No.:______________________

Name of Patient:______________________________ Date of Birth______________ Sex______________

Mailing Address:____

Signature of Insured:____ Date______________

Attending Physician's Statement

Patient's Name ____ Age ______________

1. Has patient worn glasses before this examination? ☐ Yes ☐ No	2. Did you prescribe glasses? ☐ Yes ☐ No	3. ☐ Single Vision Rx ☐ Tri-Focal Rx ☐ Bi-Focal Rx ☐ Lenticular	4. Can existing frame be used for new glasses? ☐ Yes ☐ No

Date of Services	Place of Services	Description of Services Rendered

Total Charges: $______________

Amount Paid: $______________

Balance Due: $______________

Ophthalmologist, Optometrist or Optician's Name			Federal ID No., If none, Social Security No.	
Date	Signature		Degree	Telephone
Street Address		City or Town	State	Zip

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payment of the Benefits herein specified to the above named Doctor and otherwise payable to me but not to exceed the balance due of the Doctor's regular charges for this service. I understand I am financially responsible to the Doctor for charges not covered by this assignment. I hereby authorize the above named Doctor to release the information on this form.

Date: ______________________ Signed: ____ (insured)

TO BE COMPLETED BY PROVIDER OF MATERIALS

Date materials purchased: ______________________

Lenses: $______________________

Frame: $______________________

Charges for materials only:

Total Charges: $______________

Amount Paid: $______________

Balance Due: $______________

Name and Address of Provider of Materials			Federal ID No., If none, Social Security No.	
Date	Signature		Degree	Telephone
Street Address		City or Town	State	Zip

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Date: ______________________ Signed: ____ (insured)