HARRISON TEACHER'S BENEFITS TRUST

c/o Preferred Group Plans
P.O. Box 15136, Albany, New York, NY 12212-5136
(800) 573-7474

VISION CLAIM FORM (this section to be completed by employee)

1. Employee Name		2. Social Security No.	
3. Employee's Mailing Address			
4. Patient Name (if a dependent)	5. Relationship to Employee	6. Birth Date	7. Tel. No.
8. Does Patient have other health coverage? Yes[ ] No[ ] If yes, please identify			

SERVICE PROVIDED (to be completed by provider)

Eye Examination, including Refraction $_____

Other (describe) _____

Prescription

Right	Sphere	Cylinder	Axis	Prism	Add for Reading
Left					

Did patient have eyeglasses prior to the date of your examination? Yes [ ] No [ ]

If Yes, is prescription for new lenses different from that of lenses being replaced? Yes [ ] No [ ]

Date of this examination _____

Signed _____Degree_____ Date _____

Address: _____Phone _____

Provider T.I.N. _____

TO BE COMPLETED BY PROVIDER OF MATERIALS Lenses for One Eye [ ] Both Eyes [ ]

Single Vision $ _____ Bifocal $_____ Trifocal $_____ Contact $_____ Sunglasses $_____ Other $_____

If contact lenses prescribed, give reason: _____

_____

Describe and indicated charge for special features such as hardening, tinting, plastic lenses, etc. – indicated separately from lens charge:

_____

_____ $_____

FRAMES:

All plastic, standard weight, style and hinges _____ $ _____

Combination metal and plastic _____ $ _____

All metal _____ $ _____

Other, describe _____ $ _____

Are existing framers being used for the new lenses? YES [ ] NO [ ]
If NO, give reason: _____

_____

Signed _____ Degree _____ Date_____

Address: _____

Provider T.I.N. # _____ * If examining doctor provides glasses, only one signature is necessary

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM:

_____
SIGNED (Patient or Parent if minor)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to the above physician for vision benefits otherwise payable to me for his services described on this form, but not to exceed the reasonable and customary fee for service.

Signed: _____