

**STATEMENT OF CLAIM
FOR
BOCES' STAFF DEVELOPERS VISION CARE BENEFITS**

**Mail Claim Form To:
SELE-DENT, INC.
One Huntington Quadrangle
Suite 1S03
Melville, NY 11747**

TO BE COMPLETED BY EMPLOYEE

1. Patient Name			2. Relationship to Employee Self Spouse Child Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		3. Sex M F <input type="checkbox"/> <input type="checkbox"/>	4. Patient Date of Birth Mo / Day / Year		5. If Full Time Student School City	
6. Employee Name First Middle Last		7. Employee Soc. Sec. # - -			9. Name of Group Vision Program				
8. Employee Mailing Address City State Zip					Employer (Company) Name and Address				
10. Spouse's Name			Spouse's Date of Birth Mo / Day / Year			Spouse's Soc. Sec. # - -			
11. Are other family members employed? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, indicate Name Soc. Sec. #						12. Name and address of employer in Item 11			
13. Is patient covered by another plan? Yes <input type="checkbox"/> No <input type="checkbox"/>		Plan Name	Union Local	Group No.		Name and Address of Carrier			

I authorize any individual or organization to release any information to Sele-Dent, Inc. for any services or benefits received or payable to me or on my behalf.
Required Statement: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."

Signature of Eligible Insured _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize payment of vision benefits to undersigned physician or supplier for service described below.

Signature of Insured _____ Date _____

TO BE COMPLETED BY PROVIDER OF MATERIAL OR VISION CARE SERVICES

Optometrist / Ophthalmologist / Optician			What is patient's present degree of visual activity?		
Mailing Address			Corrected _____ Uncorrected _____		
City State Zip			If tinted glasses were furnished, were they specifically prescribed for medical reasons Yes _____ No _____		
Soc. Sec. or T.I.N.	License No.	Phone # ()	Please indicate reason _____		

Diagnosis or Nature of Illness or Injury
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Description of Services	Date of Service	Fee
Examination		
Single Vision Lenses		
Bifocal Lenses		
Trifocal Lenses		
Frame Only		

Description of Services	Date of Service	Fee
Contact Lenses		
Other Charges		
Total Charges		

I hereby certify that the services/materials as indicated have been provided.

Signature _____

Date _____