MAIL COMPLETED FORM TO:
THE PREFERRED GROUP
P.O. Box 15136
Albany, NY 12212-5136
P: 518-641-0321
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GREENWOOD LAKE TEACHERS ASSOCIATION
BENEFIT TRUST FUND

# VISION CARE

Statement of Claim

**PART 1 TO BE COMPLETED BY EMPLOYEE/MEMBER**

| | | | | |
|---|---|---|---|---|
| 1. PATIENT NAME | 2.RELATIONSHIP TO INSURED<br>SELF SPOUSE CHILD OTHER | 3. SEX<br>M F | 4. PATIENT BIRTHDATE<br>MO DAY<br>YEAR | 5. IF FULL TIME STUDENT<br>SCHOOL CITY |
| 6. INSURED NAME<br>FIRST NAME MIDDLE LAST | | 7. EMPLOYEE ID Number. | | 9. EMPLOYER<br>GREENWOOD LAKES TA / 9100 |
| 8. MAILING ADDRESS | | 10 ARE OTHER MEMBERS EMPLOYED ?<br>NAME<br>If Yes, Indicate | ☐ YES ☐ NO<br>SOC. SEC. NO. LAST 4 DIGITS | |
| CITY, STATE, ZIP | | 11. NAME AND ADDRESS OF EMPLOYER IN ITEM 10 | | |
| 12. IS PATIENT COVERED BY ANOTHER PLAN ?<br>☐ YES ☐ NO | PLAN NAME UNION LOCAL | GROUP NO. | NAME AND ADDRESS OF CARRIER | |

TO: All providers of medical services and suppliers, employers, insurance institutions and other organizations, I authorize release to The Preferred Group, my employer or other representative any information, including medical, employment and benefit information required for claim processing or plan administration. This authorization is valid for one year after the date signed. A copy of this authorization shall be as valid as the original. I understand that i may request a copy of this authorization.

**Benefits assigned to provider of services:** ☐ Yes ☐ No

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and stated value of the claim for each such violation.

Signature of Insured_____ Date _____

**PART 3 TO BE COMPLETED BY OPTOMETRIST OR OPHTHALMOLOGIST**

| | |
|---|---|
| 1. OPTOMETRIST/OPTHALMOLOGIST | 7. IS TREATMENT RESULT OF OC-CUPATIONAL IL-LNESS OR INJURY ? No Yes IF YES, ENTER BRIEF DESCRIPTION AND DATES |
| 2. MAILING ADDRESS | 8. IS TREATMENT RESULT OF AUTO ACCIDENT ? |
| 3. CITY, STATE, ZIP | 9. OTHER ACCIDENT ? |
| 4. SOC.SEC. OR T.I.N. 5. LICENSE NO. 6. PHONE NO. | 10.ARE ANY SERVICES COVERED BY ANOTHER PLAN ? |

| 11. DESCRIPTION OF SERVICES | OF SERVICE | FEE |
|---|---|---|
| A. EXAMINATION | | |
| B. SINGLE VISION WITH FRAME | | |
| C. BIFOCAL WITH FRAME | DATE | |
| D. FRAME ONLY | | |
| | | |

| 11. DESCRIPTION OF SERVICES | OF SERVICE | FEE |
|---|---|---|
| E.LENSES ONLY 1) SINGLE VISION | | |
| 2) BIFOCAL | | |
| F.CONTACT LENSES | DATE | |
| G.OTHER | | |
| H.TOTAL CHARGES | | |

**12. PLEASE COMPLETE THE FOLLOWING;**

**A. WERE LENSES PRESCRIBED AS A RESULT OF EYE SURGERY ? YES_____NO_____**

**IF "YES" PLEASE SPECIFY PROCEDURE_____**

**B. WHAT IS PATIENT'S PRESENT DEGREE OF VISUAL ACUITY ?**

**CORRECTED_____UNCORRECTED _____**

**C. IF TINTED GLASSES WERE FURNISHED, WERE THEY SPECIFICALLY PRESCRIBED FOR MEDICAL REASONS?**

**YES_____NO _____**

**D. PLEASE SIGN BELOW**

_____
**SIGNATURE** **DATE**

**July 2018**