VISION CLAIM FORM

ARDSLEY CONGRESS OF TEACHERS WELFARE FUND
c/o Insurance Programmers, Inc.
60 North Main Street • P.O. Box 5817
Wallingford, CT 06492-7617
Tel.: 1-888-949-6342 or 1-800-827-1703

Providers other Than Davis or Raymond's

EMPLOYEE COMPLETE SHADED SECTIONS

1. EMPLOYEE'S NAME			2. SOCIAL SECURITY NO.	
3. EMPLOYEE'S MAILING ADDRESS	(City)		(State or Province)	(Zip Code)
4. PATIENT NAME (IF A DEPENDENT)	5. RELATIONSHIP to EMPLOYEE	6. BIRTH DATE MO. DA. YR.		7. TEL. NO.
8. DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES ☐ NO ☐ IF YES, PLEASE IDENTIFY				

SERVICE PROVIDED

Eye Examination, Including Refraction $ _____

Other (describe) _____

PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Add For Reading
Right					
Left					

Did patient have eyeglasses prior to 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 ☐

MATERIALS PROVIDED

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

If contact lenses prescribed, give reason _____

Describe and indicate charge for special features such as hardening, tinting, plastic lenses, etc. - indicate separately from lens charge.

_____ $ _____

Frames

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

Combination metal and plastic _____ $ _____

All Metal _____ $ _____

Other, describe _____ $ _____

Other Materials, describe _____ $ _____

Are existing frames 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

DATE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the above physician for medical benefits otherwise payable to me for his services described on this form, but not to exceed the reasonable and customary fee for the service.