

VISION CLAIM FORM

IMPORTANT READ CAREFULLY

*It is a crime to fill out this form with facts you know are false or to leave out facts you know are important.

1. Participant must complete Side A and have provider complete Side B.
2. Include all bills itemized to show expense incurred.
3. Be sure to show participants Social Security Number in order that we may locate your records.
4. Return completed form to this address as soon as possible:

BOILERMAKERS NATIONAL HEALTH AND WELFARE FUND
 754 Minnesota Ave., Suite 522
 Kansas City, Kansas 66101-2766

PATIENT & PARTICIPANT INFORMATION (To be completed by Participant)		(PLEASE TYPE OR PRINT)
Participant's Name _____		Date of Birth _____ <small>(Month) (Day) (Year)</small>
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
Home Address _____		Telephone No. _____
<small>(City) (State) (Zip Code)</small>		Participant's Social Security No. _____
Last Employer _____		Months Worked _____ Local _____
Is this your first claim with the Fund? _____		Are you retired? _____
Name of Patient _____		Patient's Date of Birth _____ <small>(Month) (Day) (Year)</small>
PATIENT'S SEX		Patient's Address (If Different From Participant) _____
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Single <input type="checkbox"/> Married
PATIENT'S RELATIONSHIP TO PARTICIPANT		
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
FULL TIME STUDENT - AT LEAST 12 CREDIT HOURS (Complete only if claim for child age 19 to 23)		
<input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, WHERE AND LAST DATE ATTENDED: _____		
Date first vision expense incurred _____		Was vision expense due to injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
WAS CONDITION RELATED TO:		IF AN ACCIDENT:
A. PATIENT'S EMPLOYMENT?		Date _____, 19____ AND TIME _____ <small><input type="checkbox"/> A.M. <input type="checkbox"/> P.M.</small>
<input type="checkbox"/> Yes <input type="checkbox"/> No		SPECIFIC DESCRIPTION OF HOW AND WHERE ACCIDENT OCCURRED: _____
B. AN AUTO ACCIDENT?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
C. OTHER ACCIDENT?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has claim been filed or will claim be filed under any Worker's Compensation Act or similar law? _____		
Give the provider's name and address _____		
Do you or patient have other Group Health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No. If answer is Yes, complete below:		
Do you or patient have other Group Vision coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No.		
<small>Plan Name</small> _____	<small>Name of Policy Holder</small> _____	<small>Social Security Number of Policy Holder</small> _____
<small>Plan Address</small> _____	<small>Policy Number</small> _____	
Does Plan Follow Birthday Rule? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you or patient have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No. If answer is Yes, complete the following and submit a copy of the Medicare Card(s).		
<small>Plan Name</small> _____	<small>Name of Policy Holder</small> _____	<small>Social Security Number of Policy Holder</small> _____
<small>Plan Address</small> _____	<small>Policy Number</small> _____	
IS SPOUSE EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No		
EMPLOYER'S NAME _____		
EMPLOYER'S ADDRESS _____		

CERTIFICATION AND AUTHORIZATION: I/WE certify that the above statements and answers, including any accompanying bills are true and complete to the best of our knowledge and belief. I/We know it is a crime to fill out this form with facts I/We know are false or to leave out facts I/We know are important. I/We authorize the Boilermakers National Health and Welfare Fund to release or request any medical or other information necessary to process this claim. A photocopy of this authorization shall be as valid as the original.

Participant's Signature _____

Spouse's Signature _____

Date _____

MUST HAVE BOTH SIGNATURES AND DATE

VISION CLAIM FORM — SIDE B

Patient's name and address	Birth Date
Covered participant's name if patient is a dependent (indicate address if different from patient)	Participant's Social Security Number

ATTENDING PHYSICIAN'S STATEMENT

AUTHORIZATION TO PAY: I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for the charge not covered by this authorization.

Date _____, 19____. Signed _____ (Participant)

DATE OF SERVICE	PLACE OF SERVICE	PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	DIAGNOSIS CODE	CHARGES		
Total Charge					Amount Paid	Balance Due	

I hereby certify that the above statements accurately describe the services rendered and that I am _____ (TYPE OF DOCTOR) licensed to practice by the State of _____.

Print Physician's Name	Degree	MUST BE FURNISHED UNDER AUTHORITY OF LAW			
Physician's Signature	Date	Individual Practitioner's S.S. No.			
Street Address		City or Town	State or Province	Zip Code	

STATEMENT FOR SUPPLY OF GLASSES/OTHER MATERIALS

Patient's name and address	Birth Date
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AUTHORIZATION TO PAY: I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for the charge not covered by this authorization.

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Print Physician's Name	Degree	MUST BE FURNISHED UNDER AUTHORITY OF LAW			
Physician's Signature	Date	Individual Practitioner's S.S. No.			
Street Address		City or Town	State or Province	Zip Code	