



**BRONXVILLE PUBLIC SCHOOL EMPLOYEES'
BENEFIT FUND**
C/O PREFERRED GROUP PLANS, INC.
P.O. BOX 15136 ALBANY, NY 12212-5136
(800) 573-7474 FAX (518) 641-0325

**VISION
CLAIM FORM**

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.
5. DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, PLEASE IDENTIFY			

SERVICE PROVIDED

Eye Examination, Including Refraction \$ _____

Other (describe) _____

PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Add For Reading
Right					
Left					

Did the patient have glasses prior to 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

MATERIALS PROVIDED

Lenses For One Eye Both Eyes

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

If contact lenses prescribed, give reason _____

Describe and indicate charges 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. # _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM _____

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

SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____

Signed _____

EMPLOYEE COMPLETE SHADED SECTIONS

