

# PRESCRIPTION SAFETY EYEGLASS CLAIM FORM

Return completed claim form to: **PLUMBERS AND PIPEFITTERS LOCAL No. 520 • HEALTH AND WELFARE FUND**  
**P. O. Box 6480 • HARRISBURG, PA 17112-0480**

*D. H. Evans Associates, Inc.* • Contract Administrator • (717) 671-8551

PART A — TO BE COMPLETED BY EMPLOYEE			
1. EMPLOYEE'S NAME (Last, First, Middle)	2. EMPLOYEE'S SOCIAL SECURITY NUMBER	3. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4. PATIENT'S DATE OF BIRTH
5. PATIENT'S NAME (Last, First, Middle)		6. EMPLOYEE'S ADDRESS (No., Street, City, State and Zip Code)	
7. EMPLOYER'S NAME AND ADDRESS			
8. I HEREBY AUTHORIZE any Insurance Company, Organization, Employer, Ophthalmologist, Optometrist, and Optician to release any information with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct.			
		SIGNATURE OF EMPLOYEE _____	DATE SIGNED _____
9. I HEREBY AUTHORIZE payment directly to the Dispenser/ of the Vision Care Benefits otherwise payable to me.			
<input type="checkbox"/> Yes <input type="checkbox"/> No		SIGNED (EMPLOYEE) _____	(DATE) _____

PART B - TO BE COMPLETED BY DISPENSER			
IN LIEU OF DISPENSER COMPLETING THIS SECTION A LABORATORY BILL CAN BE ATTACHED. DISPENSER MUST SIGN THIS FORM, ENTER AMOUNT BY PATIENT.			
1. DISPENSER'S NAME (Last, First, Middle)	2. TAXPAYER IDENTIFICATION No.	PROFESSIONAL SERVICES	AMOUNT
3. DISPENSER'S ADDRESS (No., Street, City, State, and Zip Code)		BASIC LENS CHARGE	
4. PHONE No. (& Area Code) ( )		BASIC FRAME CHARGE	
5. DISPENSER'S TITLE <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optician <input type="checkbox"/> Optometrist	6. MATERIALS SUPPLIED Tint No. _____ <input type="checkbox"/> Oversized <input type="checkbox"/> Glass <input type="checkbox"/> Plastic <input type="checkbox"/> Pair <input type="checkbox"/> ½ Pair <input type="checkbox"/> Other _____	7. DATE Order _____ Delivery _____	
8. TYPE OF LENSES DISPENSED <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular	9. FRAME MODEL OR CAT. No. & SIZE	OP-TIONS	LENS
10. FRAME MFT. NAME		FRM	
11. SIDE-SHIELDS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PERMANENT <input type="checkbox"/> DETACHABLE		DISP. FEE	LENS
12. I hereby certify that I have performed the services as indicated hereon.		FRM	
DISPENSER'S SIGNATURE _____ DATE _____		SALES TAX (If Any)	
I certify that I have received the materials described hereon.		TOTAL	
SIGNATURE (Employee, Spouse, Patient) _____ DATE _____		AMOUNT PAID BY PATIENT	

## EMPLOYEE INSTRUCTIONS:

### How to file a claim for Approved Prescription Safety Eyeglasses with FIXED Side Shields

Effective April 1, 1994

**Who can file:** Eligible active employees once in an 18 consecutive month period.

**What provider to use:** The Fund has endorsed a preferred safety eyeglass provider. For information on the preferred provider, you may contact the Contract Administrator or the Local Union office. Whether you choose to use the preferred provider or your own provider, the Plan will reimburse in accordance with the Plan allowance. You will be responsible for all charges in excess of the Plan allowances.

#### The claim form should be completed as follows:

1. Obtain a written prescription from your vision provider to furnish to the prescription safety eyeglass provider of your choice.
2. Complete Part A of this form. Fill in all information in items 1 through 9. Please take special care in the manner in which Item 9 is completed as it will determine who will receive payment from the Plan. In order to avoid any unnecessary delays in the processing of your claim, please make certain that all information is complete.
3. The Prescription Safety Eyeglass Provider should complete Items 1 through 12 of Part B on the form. A detailed receipt may be substituted for items 1 through 11, however the provider should still sign item 12.
4. Sign the final line of the claim form, to verify receipt of the prescription safety eyeglasses.
5. Mail the form to the Contract Administrator for processing.

**NON-PRESCRIPTION SAFETY EYEGLASSES ARE NOT COVERED BY THE PLAN**

