# INDIANA TEAMSTERS HEALTH BENEFITS FUND

6007 S. Harding St.
Indianapolis, Indiana 46217
Phone: (317) 639-3573
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## Vision Plan
## Claim Reimbursement Form

Insured Name: _____ Date: _____
Insured DOB: _____
Insured Address: _____
Insured ID#: _____
Patient Name: _____
Patient DOB: _____

Date of Eye Exam: _____
92004 Comprehensive Eye Exam/New Patient: _____
92014 Comprehensive Eye Exam/Established: _____
92310 Contact Lens Fitting: $_____
Charges Exam: $_____
Charges Fitting: _____

H52.13 Myopia: _____
H52.03 Hyperopia: _____
H52.4 Presbyopia: _____

V2020 Frame: _____

V2100 Single Vision $_____
V2200 FT_____
V2300 FT _____
V2781 Progressive _____

V2784 Poly/Trivex _____
V2783 Hi Index _____
V2750 Anti Reflective V2744 Transition _____

V2745 Tint _____
V2715 Prism _____

Doctor/Optician Signature: _____
Date: _____

**RETURN THIS FORM WITH A COPY OF YOUR PROVIDER'S BILL AND ITEMIZED PAID RECEIPT OR PROOF OF PAYMENT TO THE ABOVE ADDRESS OR EMAIL TO ITHBFMEMBER@LOCAL135.COM**

If you have any questions on your vision coverage, please call our Customer Service Department at 1-800-859-6862. Please have your Member Identification Number ready.