Auxiant
P.O. Box 75008
Cedar Rapids, IA 52407-5008
319-398-3283 or 800-475-2232

VISION CARE CLAIM FORM
IBEW Local 405
Prescription Safety Glass Claim Form

INSTRUCTIONS TO THE EMPLOYEE

(1) Complete Vision Claim Form for your prescription safety glasses

NOTE: All other vision claims should be submitted to either EyeMed or Wellmark

(2) Attach itemized bills

Employer Name: IBEW Local 405				Group Number: 451
Employee name Last	First	MI		Member ID / SSN
Employee Address		City	State	Zip
Are you currently eligible on this Plan? ☐ Yes ☐ No			If "No" give last date you were eligible:	
Patient Name Last	First		Patient Date of Birth	Relationship

Materials provided (note number prescribed): ☐ Prescription Safety Glasses _____	Date of Service: *
Total Charges:	Amount Paid:

* Claims must be filed no later than 12 months after the date services were provided.

(3) AUTHORIZATION TO RELEASE INFORMATION

I hereby certify that the foregoing statements, including any accompanying statements are true and complete to the best of my knowledge. I hereby authorize any physician, hospital, insurance company, organization or employer to release any information to including full copies of their records to Auxiant. For any medical treatment, services, or benefits rendered or payable to me. This authorization is valid from the date signed for the duration of the claim. I agree that a photocopy of this authorization shall be considered as valid as the original.

_____ _____

Signature of Employee Date

(4) Return form and attachments to:

Auxiant
Attn: Union Services
P.O. BOX 75008
Cedar Rapids, Iowa 52407-5008

(5) Your request will be processed and a check will be issued to you. Please allow up to 45 days for processing and receiving your payment.