PO Box 75008
Cedar Rapids, IA 52407-5008
319-398-3283 or 800-475-2232

VISION CARE CLAIM FORM
IBEW Local 405

INSTRUCTIONS TO THE EMPLOYEE

(1) Complete INSTRUCTION NUMBER 4 below and the PATIENT INFORMATION section (Part A) on the reverse side of this form.

(2) Have patient's physician or optometrist complete the EXAMINING PHYSICIAN or OPTOMETRIST'S INFORMATION section (Part B) on the reverse side of this form.

(3) Attach itemized bills for expenses not shown on the reverse side. If you want benefits paid directly to the Physician or Optometrist, sign the authorization at the bottom of the reverse side.

(4) Complete the following:

Employer Name IBEW LOCAL 405			Group Number 451
Employee name Last First MI			Member ID / SSN
Employee Address	City	State	Zip
Are you currently working? ☐ Yes ☐ No	If "No" give last date worked:		
Patient Name Last First	Patient Date of Birth	Relationship	
Is patient covered by any other medical benefit plan, group policy, prepayment plan, Medicare, or other Government plan? ☐ Yes ☐ No If Yes, provide type:			
Person carrying the other coverage:			
Group (employer, association, etc.):			
Insurance Company or Plan:			
Policy or Plan Number:			
Address of other Insurance Company's claim office:			

(5) Return form and attachments to:

Auxiant
PO BOX 75008
Cedar Rapids, Iowa 52407-5008

(6) AUTHORIZATION TO RELEASE INFORMATION
I hereby certify that the foregoing statements, including any accompanying statements are true and complete to the besst 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 (or my dependents). 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 ____________

Signature of the Patient (if other than the Employee) ____________________ Date ____________

Physician and/or supplier: After you have completed and signed this form, return it to the patient

Part A - Patient Information

Patient Name Last	First	MI	Patient Date of Birth	Relationship

Part B - Examining Physician or Optometrist's Information

Indicate diagnosis or Nature of Disease or Vision Disorder	
Indicate date of patient's last change of: Lenses:	Frames:

Check the materials of treatment prescribed (note number prescribed)

- ☐ Frames _______
- ☐ Single Vision _______
- ☐ Visual Training/Therapy _______
- ☐ Bifocal _______
- ☐ Trifocal _______
- ☐ Low Vision _______
- ☐ Contact Lenses _______
- ☐ Safety Glasses _______
- ☐ Other _______

Report of Services, or attached itemized bill, (if previous form submitted to Benefit Claims, you need to show only dates and services since last report.

Date of Service	Service Rendered	Charges
Date of Service	Service Rendered	Charges
Date of Service	Service Rendered	Charges
Date of Service	Service Rendered	Charges

Physician/Optometrist Information

Last	First	Phone	SSN
Address	City	State	Zip
Employee ID	Patient Account Number		
Total Charges	Amount Paid	Balance Due	

_______________________________ Physician / Optometrist's Signature

_______________ Date

I authorize payment of Vision Care Benefits to the supplier for services described in Part B.

_______________________________ Employee or Authorized Person's Signature

_______________ Date