RETURN TO:
Administrative Services Only, Inc.
Department 6-O
PO Box 9005
Lynbrook, NY 11563
(516) 396-5544 / (718) 204-7172
www.asonet.com

MOUNT VERNON FEDERATION OF TEACHERS WELFARE FUND OPTICAL REIMBURSEMENT CLAIM FORM

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name	Birth date	Relationship to Member	Full Time College Student	School
		Spouse ☐ Child ☐	Yes ☐ No ☐	

MEMBER/EMPLOYEE INFORMATION

Member Name		Birth date	Social Security# XXX-XX-☐☐☐☐
Street Address	City	State Zip	Telephone# ( )
Member's School or Work Location		Work Telephone#	

SPOUSE INFORMATION

Spouse's Name (Print)	Birth date	Social Security #	Is spouse covered by another Benefits Plan? YES ☐ NO ☐
Name, Address, Telephone # of Spouses Employer			Name of Benefit Plan

ARE ANY OTHER OPTICAL BENEFITS AVAILABLE FOR THIS PATIENT? **YES** ☐ **NO** ☐ **IS THIS AN HMO PLAN?** **YES** ☐ **NO** ☐

PROVIDER INFORMATION (EXAMINER)

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#
Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF:
Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

Certification of Examiner: I have examined the above named patient and have found the following vision defects:

Fee($)

Signature of Examiner _____ Date _____

PROVIDER INFORMATION (DISPENSER OF FRAMES AND LENSES)

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#
Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

SERVICE	FEE($)	DATE	FOR OFFICE USE
FRAMES			
LENSES Single Vision			
Bifocal			
Trifocal			
Lenticular			
Subnormal			
Contact Lenses			

Note: Limited to $150 per covered individual per calendar year with an additional $50.00 paid toward either progressive or transition lenses **OR** an additional $25.00 paid toward contact lenses. Refer to the benefit booklet published by the Fund for a complete description. This form, when completed, is to be mailed **WITH AN ORIGINAL RECEIPT MARKED "PAID"** within 90 days of the date you received the services listed .

Signature of Dispenser _____ **DATE** _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Mount Vernon Federation of Teachers Welfare Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

Signed (Patient, or Parent if Minor) _____ **DATE** _____

ASSIGNMENT OF BENEFITS: *I hereby authorize payment of the benefits (otherwise payable to me) directly to the above named physician. I understand I am financially responsible for charges not covered by this authorization.*

Signed (Member) _____ **DATE** _____

BENEFITS CANNOT BE ASSIGNED TO NON-PARTICIPATING PROVIDERS.