PRINT OR TYPE YOU ARE PREPARING MULTIPLE COPIES

READ INSTRUCTIONS ON BACK BEFORE COMPLETING FORM

PROVIDER: RETAIN LAST COPY FOR YOUR FILES, FORWARD ALL OTHER COPIES

CLAIMS MUST BE FILED WITHIN 90 DAYS FROM DATE OF TREATMENT

RETURN FORM TO: CONTRACTORS, LABORERS, TEAMSTERS AND ENGINEERS HEALTH AND WELFARE PLAN
10334 ELLISON CIRCLE
OMAHA, NEBRASKA 68134
1-402-491-3751

STATEMENT OF VISION CLAIM

PART 1

NAME OF EMPLOYEE | SOCIAL SECURITY # | AGE | EMPLOYEE'S MARITAL STATUS M. ☐ S. ☐ WID. ☐ DIV. ☐ LEGAL SEP. ☐ | ☐ MALE ☐ FEMALE

STREET ADDRESS | OCCUPATION | EMPLOYED BY | DATE EMPLOYED

CITY/STATE/ZIP | IS EMPLOYEE COVERED BY ANOTHER PLAN? ☐ YES ☐ NO IF YES PLEASE IDENTIFY

NAME OF PATIENT | RELATIONSHIP TO EMPLOYEE | BIRTHDATE OF PATIENT (MM/DD/YY) / / | EMPLOYEE'S MARITAL STATUS M. ☐ S. ☐ WID. ☐ DIV. ☐ LEGAL SEP. ☐ | ☐ MALE ☐ FEMALE | PATIENT SS #

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW PROVIDER OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN BELOW. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION

SIGNED (EMPLOYEE) DATE

I HEREBY ACCEPT THE FOLLOWING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

SIGNED (PATIENT OR PARENT IF MINOR)

PART 2

PROVIDER NAME | PROVIDER FED ID OR SS #

PROVIDER MAILING ADDRESS | PHONE #

CITY/STATE/ZIP

	YES	NO
IS PATIENT COVERED BY ANOTHER PLAN? IF YES, ENTER NAME, ADDRESS AND POLICY # OF OTHER PLAN:	☐	☐
IS ANY OF TREATMENT FOR COSMETIC PURPOSES?	☐	☐
TREATMENT RESULT OF ACCIDENT?	☐	☐
RESULT OF OCCUPATIONAL INJURY?	☐	☐

PART 3

STATEMENT OF ACTUAL SERVICES RENDERED

EXAMINATION AND TREATMENT RECORD ITEMIZED BELOW

DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MM	DD	YY	FEE		FOR FUND OFFICE USE ONLY	

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (PROVIDER) DATE

INDIVIDUAL PRACTITIONERS SS #

TOTALS

ADMINISTRATIVE USE ONLY

EFF. DATE OF INSURANCE

TERM DATE (IF ANY)

COORDINATION OF BENEFITS

	TYPE	AMOUNT CHARGE	-	AMOUNT C.O.B.	=	BALANCE DUE

DRAFT NO. ____

ISSUED DATE ____

® 2 ©

DEDUCTIBLE (IF ANY)		
COINSURANCE (PAYABLE AT) %		
TOTAL PAYMENT THIS AUDIT		

PART 1 INSTRUCTIONS FOR THE EMPLOYEE

1. Complete Part 1 of this form by answering all questions. (Please Print.)

2. Sign Part 1 of the form where indicated.

3. Take the form to your provider. The form will be completed by your Provider and sent to the Fund Office.

PARTS 2 AND 3 INSTRUCTIONS FOR THE PROVIDER

1. Complete Part 2 of this form by answering all questions. (Please Print.)

2. Upon completion of treatment, sign the original of the form (at bottom).

3. After the form is completed by your office, send the itemized form to the Fund Office for processing.

RETAIN THE LAST COPY AND SEND THE REMAINING COPIES TO THE ADDRESS SHOWN ON THE FRONT OF THE FORM AT THE TOP. IF THE PATIENT IS ELIGIBLE, BENEFITS WILL BE PAID ACCORDING TO THE PLAN'S SCHEDULE OF ALLOWANCES AND LIMITATIONS.

FAILURE TO COMPLETE THIS FORM, MAY CAUSE A DELAY IN PROCESSING THE CLAIM.

FOR ADDITIONAL INFORMATION OR ASSISTANCE, PLEASE CALL 402-491-3751.