VISION CLAIM FORM
OUT OF NETWORK

PLUMBERS & STEAMFITTERS LOCAL 21

INSTRUCTIONS FOR SUBMITTING CLAIMS

1). Answer all required questions on this side of form. Sign and date it.
2). Attach an itemized bill. (If you do not have an itemized bill Physician/Supplier to complete back of form).
3). Forward completed form to Plumbers & Steamfitters Local 21 at the address listed below for processing.

Member's Full Name: (*please print*)	S.S. #:
Home Address:	
Date of Birth:	Daytime Phone Number:
Marital Status: Single_____ Married_____ Divorced_____ Widowed_____	
Work Status: Active_____ Retired_____ Disabled_____ Other (specify)_____	

PATIENT INFORMATION

Patient Name (*Print*): _____

S.S. #: _____ Date of Birth: _____

Relationship to Member: Self_____ Spouse_____ Child_____ Other_____

Sex: Male_____ Female_____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, 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 ACT, WHICH IS A CRIME.

AUTHORIZATION FOR RELASE OF INFORMATION: We authorize the release to Local 21's Fund Office and its agents of any evidence or information about me or my dependents that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original.

_____ _____ _____ _____

Member's Signature Date Patient's Signature Date
(*Required if patient is a legal adult)*

1024 McKinley Street, Peekskill, NY 10566, Phone: (914) 737-7220, Fax: (914) 737-7283

PHYSICIAN OR SUPPLIER INFORMATION:

THIS SECTION IS TO BE COMPLETED BY THE PHYSICIAN, ONLY IF THE CLAIM IS NOT SUBMITTED WITH AN ITEMIZED BILL.

DESCRIPTION	CHARGES	TOTAL	NOTES
ROUTINE EYE EXAM			
FRAMES			
CONTACTS			
SINGLE VISION			
BI-FOCALS			
TRI-FOCALS			
PROGRESSIVE			
LENTICULAR			
OTHER (*Specify*)			
GRAND TOTAL			

Physician's or Supplier's Name, Address, and Phone Number: (*Print)*
Provider's Tax ID Number:

Complete the section below if benefits are assigned. Local 21's Fund Office will not accept an assignment of benefits without the Physicians or suppliers tax identification number:

Patient Account #:	Amount Paid:	Balance Due:

_____ _____

Provider's Signature Date