

MAIL COMPLETED FORM TO:
FITZHARRIS & COMPANY, INC.

VISION CARE
STATEMENT OF CLAIM

PO BOX 9182
 FARMINGDALE, N.Y. 11735
 (516) 777-2244 * FAX: (516) 777 777/ 78

PART 1 TO BE COMPLETED BY EMPLOYEE/MEMBER

1. Patient Name:		2. Relationship to Member: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other		3. Sex: M F	4. Patient Birthdate: Mo Day Year		5. Patient if full time student: School: City:	
6. Member Birthdate:		7. Marital Status: <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> divorced <input type="checkbox"/> widowed		8. Spouse's Name:		9. Spouse's Birthdate: Mo Day Year		10. Spouse's Soc. Sec. #:
11. Insured Name (first,middle,last):				12. Member Soc. Sec. #:		13. Group Name:		
14. Mailing Address: City, State, Zip:				15. Other Family Members Employed?: <input type="checkbox"/> yes <input type="checkbox"/> no Name: Soc. Sec. #: If yes indicate:				
17. Is patient covered by another plan? <input type="checkbox"/> yes <input type="checkbox"/> no		Plan Name:	Union Local:	Group #:	Carrier Name/Address:			

TO: All providers of medical services and supplies, employers, insurance institutions and other organizations. I authorize release to Fitzharris & Co., my employer or other representative any information, including medical, employment and benefit information required for claim processing or plan administration. This authorization is valid for one year after the date signed. A copy of this authorization shall be as valid as the original. I understand that I may request a copy of this authorization.

Benefits assigned to provider of services: yes no

Any person who knowingly, and with intent to defraud any fund or other person, files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF ELIGIBLE MEMBER: _____ DATE: _____

PART 2 TO BE COMPLETED BY OPTOMETRIST

1. Supplier:			7. Is treatment result of occupational illness or injury?: <input type="checkbox"/> yes <input type="checkbox"/> no If yes, enter brief description & dates:		
2. Mailing Address:			8. Is treatment a result of auto accident?:		
3. City, State, Zip:			9. Other accident?:		
4. Soc. Sec # or T.I.N.:		5. License #:	6. Phone #:		10. Are any services covered by another plan?:
11. Description of services			11. Description of services		
	Date of service	Fee		Date of service	Fee
A. Examination			F. Lenses Only	1. single vision	
B. Single Vision w/Frame			2. Bifocal		
C. Bifocal w/ Frame			G. Contact Lenses		
D. Frame Only			H. Other		
E. Tint			I. Total charges		
12. PLEASE COMPLETE THE FOLLOWING:			C. Indicate Diagnosis or nature of disease or visual disorder _____		
A. Were lenses prescribed as a result of eye surgery? yes _____ no _____			D. If tinted glasses were furnished, were they specifically supplied for medical reasons? Yes _____ No _____		
If yes, please specify procedure: _____			E. Please sign below: Signature: _____ Date: _____		
B. What is patients present degree of visual acuity? corrected _____ uncorrected _____					

PART 3 EMPLOYER/PLAN ADMINISTRATOR

Member:		Member ID #:		Group Name:		Policy #:		Division:	
Date Benefits Became effective: Month Day Year Month Day Year			Date Terminated: Mo Day Yr		Authorized Signature:			Date:	
EMP		DEP							

Plan Administrator Copy