Local 1070 State Employees

DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN
125 BARCLAY STREET, NEW YORK, N.Y. 10007 (212) 815-1234

CLAIM FOR DIRECT OPTICAL REIMBURSEMENT

The Optical Benefit provides three types of services once in a twelve-month period for eligible members and their dependents: eye examination, and/or frames, and/or lenses.
THE TOTAL OPTICAL BENEFIT (ALL THREE TYPES OF SERVICES) MUST BE SUBMITTED AT THE SAME TIME BY EACH COVERED PERSON (This rule applies to usage by an individual. It does not mean, for example, that all covered members in a family must use the benefit at one time.)

The Optical benefit is only available for one instance of service in each 12-month period. If only part of the Optical benefit is obtained and submitted for Direct Reimbursement, the part not utilized at the time of the first submission cannot be submitted within the same twelve months. This form must always be used if you are seeking reimbursement for non-standard frames, and other services.

EMPLOYEE

THIS SECTION IS FOR EMPLOYEE INFORMATION. PLEASE PRINT CLEARLY.

Member's Social Security No. or PID No.	Last Name	First Name

Number and Street Address	Apt. No.	City & State	Zip Code

(Area Code) Business Phone	(Area Code) Home Phone	(Area Code) Cell Phone

Department	Job Title

PATIENT

First Name

☐ EMPLOYEE ☐ SPOUSE/DOMESTIC PARTNER

☐ CHILD

Member's Signature _____ Date

PROVIDER INFORMATION

THIS SECTION IS FOR PROVIDERS

COVERED SERVICES:
Please complete the requested and applicable information:

TYPE OF SERVICE	Please Check	CHARGES
Eye Examination		$
Frames		$
Single Vision Lenses		$
Bifocal Lenses		$
Trifocal Lenses		$
Progressive Lenses		$
Contact Lenses		$
Cataract Single Vision Lenses over +8.00		$
Cataract Bifocal Lenses over +8.00		$
Cataract Contact Lenses		$
	Total	$

OTHER SERVICES:
Please complete the requested and applicable information:

TYPE OF SERVICE	Please Check	CHARGES
Solid Tints		$
High Luster Edge Polish		$
Anti-Reflective Coating		$
Polycarbonate Lenses		$
Photochromic Lenses		$
UV Protection		$
	Total	$

EXAMINER
Name: _____
Address: _____
_____
Telephone No. _____
Date of Services: _____

DISPENSER
Name: _____
Address: _____
_____
Telephone No. _____
Date of Services: _____

DC37

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Claim No.	Amount	Claim Examiner	Date