DC 37 Health & Security Plan

125 Barclay St., New York, NY 10007 | 212.815.1234

FOR INTERNAL USE ONLY

Claim #: Auto fill

Paid ◉ **Denied** ○ **Pended** ○

DC 37 Optical Reimbursement Claim Form

Important Patient Information

1. Make sure that all sections are completed, that you and the provider(s) have signed the form, and that all services, charges, proof of purchase, and dates of service have been entered. If the form is incomplete, it may result in a delay in reimbursement.
2. The completion and submission of this form does not guarantee eligibility for benefits. Please verify your eligibility and remaining balance (if applicable) by contacting DC 37 H&S Plan at 212.815.1234.
3. The patient is responsible for the costs of all treatments received and materials purchased. There is no assignment of benefits to the provider(s) for services rendered.
4. Submit the Optical Reimbursement form by mail to: DC 37 H&S Plan Optical Unit; 125 Barclay St., New York, NY 10007, by email: **Optical@DC37.net** or Fax: 212.815.1218.

Member Information

Member Name: _____ SSN# / PID#: _____

Personal Email: _____

Cell Phone: _____ Home Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Name: _____

Relationship: ○ Member ○ Spouse/Domestic Partner ○ Child

Date of Birth: _____

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Provider Information (Completed by Provider)

Examiner Name: _____ Dispenser Name: _____

Examiner Signature _____ *Dispenser Signature* _____

Service	Date of Service M	D	Y	Amount
1. Eye Examination				$
2. Frames				$
3. Single Vision Lenses				$
4. Bifocal Lenses				$
5. Trifocal Lenses				$
6. Contact Lenses				$
7. Cataract S.V. Lenses				$
8. Cataract Bifocal Lenses				$
9. Other				$
				Total:

Patient or Covered Member

I certify that the information on this form is correct and authorize the Provider to release appropriate information necessary to process this claim according to plan guidelines.

Member, Authorized Person, or Patient 18 Years or Older Signature

Date