IBEW LOCAL NO 150 WELFARE FUND

6525 Centurion Drive• Lansing, Michigan 48917
Telephone: Toll Free 877-478-4542

VISION CLAIM FORM

PARTICIPANT COMPLETES THIS SECTION

Participant Name: Member ID or SSN:

Street Address: City/State/Zip:

Patient Name: Birthdate: Relationship:

Patient Address, if different:

Is Dependent covered by any other vision care plan? ☐ YES ☐ NO

I understand that the Plan provides coverage at 50% up to $350 per person, per calendar year for lenses & frames (includes contacts) No more than one frame, lens or contacts per 12 month period. Vision exams are paid at 90%; maximum 1 vision exam per year. The services/supplies listed below have been received. I authorize the release of any information related to this claim.

Participant's Signature: Date:

I authorize payment directly to the provider of service for the amount, which is otherwise payable to me. I understand that I am responsible for any and all charges not covered by this authorization or not payable by the Fund.

Participant's Signature: Date:

PROVIDER'S STATEMENT OF SERVICE

Patient Name: Birthdate:

Are services covered by another plan? ☐ YES ☐ NO

If YES, indicate plan name and address:

If YES, enter description and dates:

ITEMIZATION OF SERVICES/SUPPLIES (Attach explanation of unusual services)

Service Date	Procedure Code	Type of Service/Supply	Charge	Amount Paid	Amount Due
		Total:	$0.00	$0.00	$0.00

I certify that the services/supplies listed above have been provided to the named patient.

Provider Signature: Date:

Provider Name:

Address:

City/State/Zip:

Tax ID Number: License Number: Telephone Number: