



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

CLAIM FOR DIRECT OPTICAL REIMBURSEMENT

PLEASE READ CAREFULLY: *Claims filed later than 30 days from the date of service will be declared ineligible.*

The Optical Benefit provides three types of services once in a two-year 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.)

When submitting Direct Reimbursement, all three types of services must be listed on the same form. If only part of the 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 two years.

The benefit cannot be split between the Optical Voucher and Direct Reimbursement.

E M P L O Y E E	THIS SECTION IS FOR EMPLOYEE INFORMATION. PLEASE PRINT CLEARLY.																																																											
	Member's Social Security No. or Personal ID No.		Last Name	First Name																																																								
	Number and Street Address		Apt. No.	City & State	Zip Code																																																							
	(Area Code) Business Phone		(Area Code) Home Phone																																																									
	Department or Institution		Job Title	Date of Employment																																																								
P A T I E N T	First Name		Name of spouse/domestic partner's employer																																																									
			Name of spouse/domestic partner's insurance carrier																																																									
	<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE/DOMESTIC PARTNER																																																											
	<input type="checkbox"/> CHILD AGE _____		Member's Signature	Date																																																								
P R O V I D E R	THIS SECTION IS FOR PROVIDERS																																																											
	SERVICES:																																																											
	Please complete the requested and applicable information:																																																											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">TYPE OF SERVICE</th> <th style="width: 10%;">Please Check</th> <th style="width: 20%;">CHARGES</th> </tr> </thead> <tbody> <tr><td>Eye Examination</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;">\$</td></tr> <tr><td>Frames</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;">\$</td></tr> <tr><td>Single Vision Lenses</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;">\$</td></tr> <tr><td>Bifocal Lenses</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;">\$</td></tr> <tr><td>Trifocal Lenses</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;">\$</td></tr> <tr><td>Progressive Lenses</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;">\$</td></tr> <tr><td>Contact Lenses</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;">\$</td></tr> <tr><td>Cataract Single Vision Lenses over +8.00</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;">\$</td></tr> <tr><td>Cataract Bifocal Lenses over +8.00</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;">\$</td></tr> <tr><td>Cataract Contact Lenses</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;">\$</td></tr> <tr><td style="text-align: right;">Total</td><td></td><td style="text-align: center;">\$</td></tr> </tbody> </table>		TYPE OF SERVICE	Please Check	CHARGES	Eye Examination	<input type="checkbox"/>	\$	Frames	<input type="checkbox"/>	\$	Single Vision Lenses	<input type="checkbox"/>	\$	Bifocal Lenses	<input type="checkbox"/>	\$	Trifocal Lenses	<input type="checkbox"/>	\$	Progressive Lenses	<input type="checkbox"/>	\$	Contact Lenses	<input type="checkbox"/>	\$	Cataract Single Vision Lenses over +8.00	<input type="checkbox"/>	\$	Cataract Bifocal Lenses over +8.00	<input type="checkbox"/>	\$	Cataract Contact Lenses	<input type="checkbox"/>	\$	Total		\$	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td colspan="2">EXAMINER</td></tr> <tr><td>Name</td><td>_____</td></tr> <tr><td>Address</td><td>_____</td></tr> <tr><td>Telephone No.</td><td>_____</td></tr> <tr><td>Date of Services</td><td>_____</td></tr> <tr><td colspan="2">DISPENSER</td></tr> <tr><td>Name</td><td>_____</td></tr> <tr><td>Address</td><td>_____</td></tr> <tr><td>Telephone No.</td><td>_____</td></tr> <tr><td>Date of Services</td><td>_____</td></tr> </table>		EXAMINER		Name	_____	Address	_____	Telephone No.	_____	Date of Services	_____	DISPENSER		Name	_____	Address	_____	Telephone No.	_____	Date of Services	_____
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