

# IBEW LOCAL 234 HEALTH AND WELFARE PLAN

**Send Claims to:**

IBEW Local 234 Health and Welfare Plan  
 P O Box 2458  
 San Jose, CA 95109

## VISION CLAIM FORM

**For Eligibility & benefits please call**  
 877-885-3753 or  
 408-588-3753

TO BE COMPLETED BY EMPLOYEE					
Patient's Name (Last Name First)			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Employee's Complete Name and Address Name:		Employee's Soc. Sec. No.		Patient's Birthdate	
Street No.:				Mo.      Da.      Yr.	
City, State, Zip Code:				Relationship to Employee	
				<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Name of Employer		Location:		Date Employed:	
Other Medical Coverage? If "YES", Name of Carrier. If other coverage, give Identification Number.					
Reimbursement Check Please send to:					
<input type="checkbox"/> Provider <input type="checkbox"/> Employee					
This Condition was caused by:		If Injury, Date sustained, How and Where sustained:			
<input type="checkbox"/> Illness <input type="checkbox"/> Injury					
Is Condition due to injury or sickness arising out of patient's employment?					
<input type="checkbox"/> YES <input type="checkbox"/> NO					
TO BE COMPLETED BY EXAMINING PHYSICIAN					
If you prescribed glasses, check type:			PHYSICIAN'S PRESCRIPTION		
<input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal					
Tint prescribed? <input type="checkbox"/> YES <input type="checkbox"/> NO			R.E.	●	●
Has Cataract Surgery been performed?			L.E.	●	●
<input type="checkbox"/> YES <input type="checkbox"/> NO      Date:					
Can Visual Acuity be restored to at least 20/70 in the better Eye with Conventional Glasses?			Reading Addition	R.E.	+ ●
<input type="checkbox"/> YES <input type="checkbox"/> NO				L.E.	+ ●
R.V.S. No or Diagnosis:					
PHYSICIAN'S Name and Address:		Physician Specialty		IRS Taxpayer's No	
		Physician Phone No.		County	
				Examination Date of Service	
PHYSICIAN'S SIGNATURE:		DATE:		Certificate No.	
				Examination Fee	
TO BE COMPLETED BY SUPPLIER OF LENSES OR FRAMES					
Lenses & Frame		Bifocals		Name of Frame Type	
<input type="checkbox"/>		<input type="checkbox"/>			
Frame Only		Lenses Only		Contact Lenses	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Therapeutic	
				<input type="checkbox"/> Cosmetic	
Other (Shatterproofing – Special lenses were required)				Supplier's Complete Name & Address	
<input type="checkbox"/>					
Were any of the above charges for sunglasses?				IRS Taxpayer's Number	
<input type="checkbox"/> YES <input type="checkbox"/> NO					
				Authorized signature of supplier	
				Date:	
The above answers are true and complete according to the best of my knowledge and belief. I hereby Authorize this physicians or supplier to furnish and disclose all facts concerning this service.			Authorization of payment to be released to:		
			<input type="checkbox"/> Provider		
			<input type="checkbox"/> Employee		
			Please check only one.		
PATIENT'S SIGNATURE (or parent if patient is a minor)			EMPLOYEE'S SIGNATURE		
DATE			DATE		

