

Ph: (323) 666-8910



SOUTHERN CALIFORNIA DRUG BENEFIT FUND VISION CARE CLAIM FORM

Return to:
P.O. Box 27920
Los Angeles CA 90027-0920

PARTICIPANT INFORMATION

(Please fill out this section whether the claim is on behalf of participant or dependent. Please print clearly)

New address?

Yes
 No

First Name _____ MI _____ Last Name _____ DOB _____

Address _____ City/State/Zip _____

SSN xxx-xx-____ or ID: DF _____ Please check applicable: Male Female Married or Domestic Partner Single

DEPENDENT INFORMATION

(Please fill out this section only if claim is on behalf of a dependent.) Spouse/DomPart Child

First Name _____ M.I. _____ Last Name _____ DOB __/__/____

CERTIFICATION

(You **must** sign this section for your claim to be processed.) I hereby certify the statements hereon are true and correct to the best of my knowledge and I authorize any physician, surgeon, practitioner or other person, any hospital, including Veterans Administration or government hospital, any medical service organization, any insurance company, or other institution or organization, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other claims. A photostat of this authorization shall be as valid as the original. I understand that it is fraudulent to fill out this form with information I know to be false or to omit important facts, and that criminal and/or civil penalties can result from such acts.

Participant's Signature _____ Date _____

ASSIGNMENT OF BENEFITS

(Sign this section if you want benefits paid directly to the provider.)

I hereby authorize payment directly to the below-named provider of the benefits otherwise payable to me under this Plan. I understand I am financially responsible to the provider for charges not covered by this assignment.

Participant's Signature _____ Date _____

If participant is submitting this form to the Southern California Drug Benefit Fund for reimbursement, please attach receipts to this claim entry. Benefits will be paid only if (1) applicable receipts are attached OR (2) if Provider completes below section.

ATTENDING PHYSICIAN'S OR OPTOMETRIST'S STATEMENT

(to be completed by provider only)

VISION CARE SERVICES (If vision care services were provided, please complete this section.)

Was corrective eyewear ordered? <input type="checkbox"/> Yes; Date Ordered _____ <input type="checkbox"/> No	Date of Exam: _____	CHARGES & SERVICES RENDERED
Were glasses prescribed? <input type="checkbox"/> Yes; Delivery Date _____ <input type="checkbox"/> No	Refractions? <input type="checkbox"/> Yes <input type="checkbox"/> No	Examination Fee: \$ _____
Does patient have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was corrective eyewear dispensed?? <input type="checkbox"/> Yes <input type="checkbox"/> No	Single Vision Lenses: (Number) _____ \$ _____
		Bifocal Lenses: (Number) _____ \$ _____
		Trifocal Lenses: (Number) _____ \$ _____
		Other: (Number) _____ \$ _____
		Frames: \$ _____
		Total Charges: \$ _____

PROVIDER'S CERTIFICATION

I hereby authorize Southern California United Food and Commercial Workers Unions Drug Benefit Fund to examine the patient's medical records upon presentation of authorization signed by the patient or a qualified person.

Practitioner's Tax ID _____ Practitioner's License No. _____

Provider's Name _____ Degree _____ Phone _____

Mailing Address, City, State, Zip _____

Signature _____ Date _____