VISION CLAIM FORM

ullico
The Union Labor Life Insurance Company

[redacted]

Communications Workers Local 1109 Welfare Fund
Tel. No.: (718) 444-1119
c/o The union Labor Life Insurance Company
P.O. Box 61593
King of Prussia, PA 19406
(Toll Free) Tel. No.: 1-877-800-2956

Member's Name (print in full)	Policy or Plan No.	Social Security Number
	C-3968	☐☐☐ – ☐☐ – ☐☐☐☐
Home Address	Date of Birth	Daytime Phone Number
	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed	Work Status ☐ Active ☐ Disabled ☐ Retired ☐ Other (specify)
City State Zip		

PATIENT INFORMATION

Name	Date of Birth
Social Security Number	
Relationship to Member ☐ Self ☐ Spouse ☐ Child ☐ Other (specify)	Sex ☐ Male ☐ Female
If Patient is Child: Is he/she married? ☐ Yes ☐ No; Is he/she a full-time student? ☐ Yes ☐ No	
If Patient is a legal adult, patient's signature is required under Authorization for Release of Information.	

SPOUSE INFORMATION

Name	Date of Birth
Social Security Number	Employment Status ☐ Active ☐ Retired ☐ Not Employed
Employer Name and Address	

If treatment is for an injury, describe injury and explain how and where it occurred.

Date injury occurred	Did injury occur at work? ☐ Yes ☐ No	Was injury caused by a motor vehicle accident? ☐ Yes ☐ No If Yes, specify city and state above.

IF YOU OR ANY MEMBER OF YOUR FAMILY IS COVERED UNDER ANOTHER GROUP VISION PLAN, COMPLETE THE FOLLOWING SECTION.

Covered Family Member ☐ Self ☐ Patient ☐ Spouse ☐ Other: specify Name and Relationship			Name and Address of Insurance Company
Policy or Plan No.	Insurance ID Number	Type of Coverage ☐ Individual ☐ Family	

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

AUTHORIZATION FOR RELEASE OF INFORMATION: I/We authorize the release to ULLICO and its agents of any evidence or information about me or my dependents that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original. (Patient's signature is required if patient is a legal adult.)

Member's Signature Date Patient's Signature Date

INSTRUCTIONS FOR MAKING CLAIM FOR BENEFITS
1. Answer all required questions on this side of form, and sign it.
2. If you want us to pay the hospital or doctor directly, sign the "Assignment of Benefits" section on the reverse.
3. Have the doctor complete his section or attach an itemized bill indicating the patient's name, diagnosis, the type, place and date of each service, and the amount charged.

THIS SECTION TO BE COMPLETED BY POLICYHOLDER

Member Effective Date	Member Termination Date
I certify that the patient named in this claim was eligible for vision benefits during the period specified above.	
Policyholder's Representative Date	

CLM-14 (REV. 6/01)

ASSIGNMENT OF BENEFITS	I authorize payment of benefits to the undersigned physician or supplier for the services described below.
	Member's Signature _____ Date _____

PHYSICIAN OR SUPPLIER INFORMATION: These sections to be completed by physician unless claim is submitted with an itemized bill.

NO.	TYPE OF LENS (✓) EYEGLASSES	CONTACT	SINGLE VISION	BI-FOCAL	TRI-FOCAL	LENTICULAR	DATE LENSES ORDERED	CHARGES LENSES	TINTING*	FRAMES	TOTAL
								.	.	.	.
								.	.	.	.
								.	.	.	.
CHARGES FOR LENSES AND FRAMES								.	.	.	.

ROUTINE EYE EXAMINATION DATE: _____ CHARGE: .

TOTAL CHARGES FOR ROUTINE EYE EXAMINATION, LENSES, AND FRAMES: .

* TINTING	Is tint prescribed? ☐ Yes ☐ No If yes, for what condition?
Type of Tint ☐ Light Tint ☐ Sunglasses	

When should tinted eyeglasses be worn? When not?

OTHER SERVICES. This form is for reporting claims payable under a **Vision Care** benefit, which usually covers only the following (subject to certain limitations):

(1) **Routine eye examinations** for determining general eye health and evaluating visual function, including prescription for correction of visual problems; and

(2) **Pairs of eyeglass lenses or contact lenses** prescribed as a result of such an examination, and **eyeglass frames.**

However, some policies include a **Subnormal Vision Care** benefit, which covers other services for improvement of vision in individuals with less than 20/70 visual acuity in the better eye. Describe any such services in the section below.

ADDITIONAL SERVICES, EQUIPMENT OR SUPPLIES PROVIDED OR PRESCRIBED FOR SUBNORMAL VISION CARE	DATE PROVIDED	CHARGE
		.
		.
		.
		.

IMPROVEMENT OF VISION	LEFT EYE	RIGHT EYE	BOTH EYES
Vision without aid or before treatment			
Vision with aid or after treatment			

Total Charges for Subnormal Vision Care .

Total Charges for All Vision Care .

Physician's or Supplier's Name, Address, and Phone Number (print)

Provider's Signature Date

COMPLETE THE SECTION BELOW IF BENEFITS ARE ASSIGNED.
ULLICO WILL NOT ACCEPT AN ASSIGNMENT OF BENEFITS WITHOUT THE PHYSICIAN'S OR SUPPLIER'S TAX IDENTIFICATION NUMBER.

Patient's Account Number	Amount Paid .
Provider's Tax ID Number	Balance Due .