AFSCME CARE Plan

Return This Form to:
OHIO AFSCME CARE PLAN
1603 East 27th Street
Cleveland, Ohio 44114
Phone: (216) 781-6420

STATEMENT OF CLAIM
VISION CARE BENEFITS

☐ Check Box for Address Change

For All Claims

NAME OF EMPLOYEE | S.S.# | MALE ☐ FEMALE ☐ | DATE OF BIRTH DAY MO. YEAR | EMPLOYED BY

EMPLOYEE'S ADDRESS | STREET & NO. | CITY | STATE | ZIP CODE

TELEPHONE

For Dependent Claims

NAME OF DEPENDENT | MARRIED ☐ SINGLE ☐ | RELATIONSHIP TO EMPLOYEE | DATE OF BIRTH DAY MO. YEAR

IS DEPENDENT EMPLOYED? | NAME AND ADDRESS OF DEPENDENT'S EMPLOYER

For All Claims

ARE YOU OR YOUR DEPENDENT INSURED FOR VISION CARE BENEFITS PROVIDED UNDER ANY OTHER EMPLOYER, UNION, ASSOCIATION, BLUE CROSS, BLUE SHIELD OR OTHER GROUP INSURANCE PLAN? YES ☐ NO ☐
IF YES INSERT POLICY NUMBER, NAME AND ADDRESS OF INSURANCE COMPANY OR ORGANIZATION PROVIDING SUCH BENEFITS OR SERVICES.

POLICY NO. | CERT. NO. | NAME AND ADDRESS

I HAVE READ THE FORGOING TREATMENT PLAN, I AUTHORIZE RELEASE OF ANY INFORMATION TO THIS CLAIM.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DOCTOR OR PROVIDER OF BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

SIGNED (PATIENT OR PARENT IF MINOR) DATE | SIGNED (INSURED PERSON) DATE

TO BE COMPLETED BY THE DOCTOR OR PROVIDER OF SERVICE

date service began | date service completed

Is this a replacement? YES ☐ NO ☐
If "yes" please give reason for replacement

print or type doctor's or provider's name

doctor's or provider's address

city – state – zip code

doctor's or provider's signature

telephone number

date

MUST BE FURNISHED UNDER AUTHORITY OF LAW
INDIVIDUAL PRACTITIONER – SS#
ALL OTHERS – EMPLOYER I.D. #

	YES	NO		LEVEL THREE PROC*
including tonometry	☐	☐	$ examination	
including refraction	☐	☐		
			$ frames	
	one ☐	two ☐	lenses: single vision	Hi-Indx (SV) 1.66
	one ☐	two ☐	lenses: bifocal, kryptick	Hi-Indx (SV) 1.66
	one ☐	two ☐	lenses: bifocal, flatop	Poly Carb (SV)
	one ☐	two ☐	lenses: trifocal	Poly Carb (MF)
	one ☐	two ☐	lenses contact	solid tint coat
	one ☐	two ☐	lenses contact	scratch resi coat
			lenses: lenticular	basic prg lense

Total Charges $