VISION FORM

RETURN COMPLETED FORM TO:
A.P.A.I.E. TEAMSTERS LOCAL 618
HEALTH AND WELFARE OFFICE
9040 LACKLAND ROAD, SUITE B
ST. LOUIS, MISSOURI 63114

Phone: 314-426-5909
Facsimile: 314-426-1180
Additional forms may by downloaded at
www.618health.org

INSTRUCTIONS: This form is to be completed by the member and the doctor. Complete member's section fully, be sure to sign member's signature section and show member's Social Security Number. Remember to attach all itemized bills.

MEMBER COMPLETES AND SIGNS THIS SECTION

Name of Member_____Date of Birth____/____/_____

Social Security Number_____ Home Phone:_____

Home Address: Street:_____

City_____State_____Zip:_____

Complete if claim is for dependent: Name_____

Relationship_____Date of Birth____/____/_____

I hereby authorize A.P.A.I.E. Local 618 Health and Welfare, and provider to release or obtain any information necessary to determine benefits paid or payable concerning this or other vision claims. Also I certify that, to the best of my knowledge, the information furnished is true and correct. I understand that failure to answer these questions truthfully could forfeit payment of benefits under my insurance coverage. A copy of this authorization shall be valid as the original.

_____ ____/____/_____
Member's Signature Date

TO BE COMPLETED BY PHYSICIAN OR REGISTERED OPTOMETRIST

Patient's Name_____ Date of Birth_____

1. Is Eye condition work related? **Yes_____No_____**
2. Is replacement of lens or frames due to being lost or stolen? **Yes_____No_____**
3. Were glasses Prescribed? **Yes_____No_____**

EXAMINATION

$_____ DATE_____

Single Vision	Bi-Focal	Tri-Focal	Lenticular
$_____	$_____	$_____	$_____

Contacts	Frames
$_____	$_____

OPTICAL COMPANY:
Doctor Signs Here:_____ **Date_____ Date Delivered_____**

TIN #_____
Must Have for Assigned Benefits

I hereby Authorize payment directly to the Provider

Optical Company

Address City State Zip