RETURN TO:
SIDS
Department 28-O
PO Box 9005
Lynbrook, NY 11563
(516) 396-5544 / (718) 204-7172
www.asonet.com

PORT CHESTER TEACHERS ASSOCIATION
WELFARE TRUST FUND
OPTICAL FORM

****All claims must have a separate Rx in order to be processed****

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name	Birth date	Relationship to Member Spouse ☐ Child ☐	Full Time College Student Yes ☐ No ☐	School

MEMBER/EMPLOYEE INFORMATION

Member Name		Birth date	Last 4 Digits of Social Security#
Street Address	City	State Zip	Telephone# ( )
Member's School or Work Location		Work Telephone#	

SPOUSE INFORMATION

Spouse's Name (Print)	Birth date	Social Security #	Is spouse covered by another Benefits Plan? YES ☐ NO ☐
Name, Address, Telephone # of Spouses Employer			Name of Benefit Plan

ARE ANY OTHER OPTICAL BENEFITS AVAILABLE FOR THIS PATIENT? YES ☐ NO ☐ **IS THIS AN HMO PLAN? YES ☐ NO ☐**

PROVIDER INFORMATION (EXAMINER)

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#
Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF:
Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

Certification of Examiner: I have examined the above named patient and have found the following vision defects:

Fee($)

Signature of Examiner_____ Date _____

PROVIDER INFORMATION (DISPENSER OF FRAMES AND LENSES) ***In order to process claim, please send separate Rx with claim form***

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#
Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

SERVICE		FEE($)	DATE	FOR OFFICE USE
FRAMES				
LENSES	Single Vision			
	Bifocal			
	Trifocal			
	Lenticular			
	Subnormal			
	Contact Lenses			

Signature of Dispenser_____ **DATE** _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, 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 TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Port Chester Teachers Association Welfare Trust Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

Signed (Patient, or Parent if Minor)_____ **DATE** _____

ASSIGNMENT OF BENEFITS: *I hereby authorize payment of the benefits (otherwise payable to me) directly to the above named physician. I understand I am financially responsible for charges not covered by this authorization.*

Signed (Member)_____ **DATE** _____