Vision Care Plan • Statement of Claim ALL INFORMATION MUST BE COMPLETED ON THIS FORM

INSTRUCTIONS:

- Employee completes Part 1 of this form.
- 2. Your optometrist, ophthalmologist, or optician completes Part 2 of this form.
- 3. A separate Claim Form is required for each family member.
- 4. One Claim Form is to be used for all services.
- 5. PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS
 TO SUBMIT YOUR CLAIM FORM TO VBA: 1) MAIL OR FAX TO THE
 ADDRESS AND/OR NUMBER LISTED BELOW OR COMPLETE THE
 EDITABLE FORM AND UPLOAD YOUR RECEIPTS ON OUR WEBSITE,
 VBAPLANS.COM WITHIN 180 DAYS FROM THE DATE OF SERVICE.

If you have any questions regarding the completion of this form, please contact your Personnel Office or Health & Welfare office.

| PART 1 To be completed by Employee (please print or type) | | | | | | | | |
|---|--------------------------|------------------------|--|--|--|--|--|--|
| EMPLOYEE'S FULL NAME (LAST, FIRST, MIDDLE) | | SOCIAL SECURITY NUMBER | VBA CO# #652 Midwestern PA School EE Benefits Consortium | | | | | |
| HOME ADDRESS | | CITY STATE ZIP | | | | | | |
| PATIENT'S FULL NAME (LAST, FIRST, MIDDLE) | RELATIONSHIP TO EMPLOYEE | BIRTHDATE | | | | | | |
| | SELF - SPOUSE - CHILD - | | | | | | | |
| THIS CLAIM IS NOT FOR TREATMENT OF AN OCCUPATIONAL ACCIDENT AND I HEREBY AUTHORIZE ANY OF THE UNDERSIGNED TO DISCLOSE ANY NECESSARY INFORMATION TO THIS CLAIM I CERTIFY TO THESE STATEMENTS | | | | | | | | |
| MEMBER/EMPLOYEE SIGNATURE | DATE | | | | | | | |

USE ONE FORM FOR EACH BENEFICIARY

| PART 2 To be completed by optometrist, ophthalmologist or optician (please print or type) | | | | | | | | |
|---|--|-------------|--|--------------|----------|-------------|--|--|
| E | PRACTICE NAME | CIRCLE ONE | PLEASE MARK THE SERVICE FOR THE TYPE OF EXAM PERFORMED | | | | | |
| X A M | OD MD | | VISION ANALYSIS TONC | | TONOM | METRY 🗆 | | |
| | ADDRESS | | DID YOU PRESCRIBE? YES \(\text{NO} \(\text{O} \) | DATE OF EXAM | | EXAM CHARGE | | |
| | CITY STATE | ZIP CODE | EXAMINING DOCTOR | L | | | | |
| | | | SIGNATURE | | | DATE | | |
| | TELEPHONE NUMBER (INCLUDE AREA CODE) | | | | | | | |
| L E N S E S | DISPENSING PRACTICE NAME IF DIFFERENT FROM EXAMINING PRACT | TICE | DATE ORDERED | | | | | |
| | ADDRESS | | PLEASE INDICATE SEPARATE BASIC LENS CHARGE | | | | | |
| | CITY STATE | ZIP CODE | SINGLE VISION BIFOCAL | | \$ \$ | | | |
| | TELEPHONE NUMBER (INCLUDE AREA CODE) | | TRIFOCAL | | \$ \$ | | | |
| | | | LENTICULAR | | \$ | | | |
| | DISPENSING DOCTOR/OPTICIAN | | ELECTIVE CONTACTS \$ | | | | | |
| | SIGNATURE DAT | E | MEDICAL REQ'D CONTACTS \$ | | | | | |
| F | IF A NEW FRAME IS SUPPLIED, PLEASE INDI | CATE CHARGE | | | | \$ | | |
| R A M E | | | | TOTAL CH | | \$ | | |

ATTACH YOUR RECEIPTS TO THIS CLAIM FORM AND MAIL / FAX / UPLOAD TO: VISION BENEFITS OF AMERICA