



# VISION CLAIM FORM

1. Complete the front section of this claim form
2. Have the provider complete the back of this claim form or attach a complete itemized bill to this claim form.
3. Send the original claim to: IUOE • Local 399 Health & Welfare Fund  
c/o Elite Administration  
310 S. Racine Avenue • Suite 700 • Chicago, IL 60607  
For Assistance, call (312) 236-2157

## PLEASE COMPLETE A SEPARATE CLAIM FORM FOR EACH FAMILY MEMBER

TO BE COMPLETED BY THE MEMBER (Please print or type)

### MEMBER INFORMATION

Member First Name	MI	Last Name	
_____			
Home Address	City	State	Zip Code
_____			
Social Security or BCBS ID#	Employer		
_____			

### PATIENT INFORMATION

Patient First Name	MI	Last Name	
_____			
Patient Relationship to Member:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
	Patient Date of Birth: ____/____/____		
Is patient a full time college student?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", please provide school name: _____

### IF MEMBER IS TO BE REIMBURSED - SIGN THIS SECTION

I request payment be made to me:

Member: \_\_\_\_\_ Date: \_\_\_\_\_

### IF PROVIDER IS TO BE REIMBURSED - SIGN THIS SECTION

I hereby authorize payment directly to the provider of service

Member: \_\_\_\_\_ Date: \_\_\_\_\_

### CERTIFICATION:

As the member, **YOU MUST SIGN AND DATE THIS CLAIM FORM** – I hereby authorize the provider to release any information requested with respect to this claim and/or the attached bill. **I CERTIFY THAT THE INFORMATION FURNISHED BY ME IN SUPPORT OF THIS CLAIM IS TRUE AND CORRECT.**

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

