CANTON ELECTRICAL LOCAL 540
WELFARE FUND
33 FITCH BLVD
AUSTINTOWN, OH 44515

STATEMENT OF CLAIM FOR VISION CARE

Patient Information

Full Name _____ Birthdate ___/___/___ ☐ Self ☐ Child ☐ Spouse ☐ Other Relation to Insured

Employee Information

Full Name _____ Employee Social Security Number _____

Address _____ Birthdate ___/___/___ Phone Number _____

City _____ State _____ ZIP _____ Employer _____

Were any of the expenses covered by Workers' Compensation? Yes ☐ No ☐

Is the patient covered under any other vision care plan? Yes ☐ No ☐
If Yes, Complete Other Insurance Information. If Other Insurance is Primary to this claim, please include a copy of the explanation of benefits with this claim form.

Other Insurance Information

Full Name of Other Insured _____ Birthdate ___/___/___ ☐ Self ☐ Child ☐ Spouse ☐ Other Relation to Patient

Name of Carrier _____ Social Security Number _____

Address of Carrier _____ Group Number _____

City _____ State _____ ZIP _____ Employer/Group Name _____

Authorization of Information Release

The above answers are true to the best of my knowledge. I hereby authorize any doctor or optician, any insurance company, or other organization to release any information required, including benefits paid or payable.

Employee's Signature _____ Date _____

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

Assignment of Benefits to Provider

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE IF DIRECT PAYMENT OF BENEFITS TO THE PROVIDER IS DESIRED. (May not be honored if signed by any person other than employee.)

I hereby authorize payment directly to the provider of the group insurance benefits otherwise payable to me, but not to exceed the charges shown.

Employee's Signature _____ Date _____

NOTES TO PROVIDER: Schedules of Benefits must be provided by the employees if needed by the provider. If the professional entity performing the examination is different from the entity providing materials, two forms need to be completed. Photocopies of this form will be accepted. Similar Itemized Superbills will be accepted as replacement for the back of this form if the questions below are answered. Employer/Tax Identification Numbers must be provided if assignment of benefits is accepted.

Patient: _____

Date of Service: _____ Date Materials Dispensed: _____

DIAGNOSIS ICDM-9-CM

❑ Amblyopia R L	368.00	❑ Foreign Body	930.00
❑ Anisometropia	367.31	❑ Glaucoma, Sus	365.00
❑ Aphakia R L	379.31	❑ Headache per HX	784.00
❑ Asthenopia	368.13	❑ Headache, migm	346.90
❑ Astigmatism	367.20	❑ Hem., Conjunct	372.72
❑ Blepharitis	373.00	❑ Hordeolum	372.10
❑ Blepharoconj	372.20	❑ Hypertens. Ocular	365.04
❑ Cataract R L	366.90	❑ Hypertens. per HX	401.90
❑ Chalazion	373.20	❑ Hyperopia	367.00
❑ Conjunctivitis	372.00	❑ Keratitis	370.20
❑ Corneal Abrasion	918.10	❑ KCS	370.33
❑ Corneal Degen	371.10	❑ Keratoconus	371.60
❑ Corneal Dystro	371.50	❑ Macular Degen.	362.50
❑ Corneal Edema	371.20	❑ Muscae Vol.	379.24
❑ Diabetes per HX	250.50	❑ Myopia	367.10
❑ Diabetic Retino	362.00	❑ Pannus	370.62
❑ Diplopia	368.20	❑ Pinguecula	372.51
❑ Dry Eye Syn	375.15	❑ Presbyopia	367.40
❑ Emmetropia	V65.50	❑ Retinal Degen.	362.60
❑ Episcleritis	379.00	❑ Retinal Detach	361.90
❑ Esophoria	378.41	❑ Retinopathy	362.10
❑ Esotropia	378.00	❑ Trichiasis	374.05
❑ Exophoria	378.42	❑ Visual Disturb	368.10
❑ Exotropia	378.10	❑ Vis. Field Defect	368.40
❑ Eyestrain	368.13	❑ Xanthelasma	374.51
❑ Eye Muscle Imbal	378.90	❑ _____	_____
		❑ _____	_____

R		SPHERICAL	CYLINDRICAL	AXIS	PRISM	BASE
DISTANCE	O.D.					
	O.S.					
ADD	O.D.		ADDITIONAL SPECIFICATIONS:			
	O.S.		EXPIRATION DATE _____			

PROFESSIONAL SERVICES

	New	Est.	Fee
❑ Examination, Brief	❑ 90000	❑ 90040	_____
❑ Exam., Limited	❑ 90010	❑ 90050	_____
	❑ 92002	❑ 92012	_____
❑ Exam., Intermediate	❑ 90015	❑ 90060	_____
	❑ 92004	❑ 92014	_____
❑ Exam., Comprehensive	❑ 90020	❑ 90080	_____
Refraction Included?	❑ Yes	❑ No	
❑ Refraction, w/o Exam.		W0647	_____
❑ Examination, Emergency		99065	_____
❑ Consultation		90620	_____
❑ Opthalmoscopy, Extended		92225	_____
❑ Photography, External Ocular		92285	_____
❑ Photography, Internal Opthal. Fundus		92250	_____
❑ Gonioscopy		92020	_____
❑ Orthoptic Evaluation		92060	_____
❑ Orthoptic Therapy		92065	_____
❑ Visual Field Exam., Central		92081	_____
❑ Visual Field Exam., Peripheral		92082	_____
❑ Serial Tonometry		92100	_____
❑ Color Vision Examination		92283	_____
❑ Low Vision Examination		98312	_____
❑ Medications/Supplies _____		99070	_____
❑ Special Report		99080	_____
❑ Other _____			_____
❑ Other _____			_____

CONTACT LENS PROFESSIONAL SERVICES

		Fee
❑ Contact Lens Diagnostic Exam/ Prescribing & Fitting	92310.26	_____
For Treatment of Disease	92070	_____
❑ Contact Lens Diagnostic Exam/ Prescribing (Aphakic)	92312	_____
❑ C.L. Progress Evaluation	_____	_____
❑ Contact Lens Modification	92325	_____
❑ Contact Lens Polishing	_____	_____
❑ C.L. Care Program/Svc. Agr.	_____	_____
❑ Other _____		_____
❑ Other _____		_____

SPECTACLE SERVICES

❑ Glass ❑ Plastic ❑ 1 Lens ❑ 2 Lenses ❑ Polycarbonate

	Aphakic	Non-Aph.	Fee
❑ Single Vision	❑ V2103	❑ 92340	_____
❑ Bifocal	❑ V2203	❑ 92341	_____
❑ Trifocal	❑ V2303	❑ 92342	_____
❑ Seamless/Progressive Multifocal		_____	_____
❑ Aspheric Bifocal	❑ V2430	_____	_____
❑ Prism		V2715	_____
❑ Tint req. for photophobia		V2740	_____
❑ Rimless		V27___	_____
❑ Cosmetic/Fashion Tint		V2741	
❑ Photogrey Tint		_____	_____
❑ Photochromic		V2744	_____
❑ Oversize		V2780	_____
❑ Scratch Resistant Coating		V2760	_____
❑ Ultraviolet Coating		V2755	_____
❑ Anti-Reflective Coating		V2750	_____
❑ Polycarbonate		_____	_____
❑ Low Vision Aid	❑ 2600	❑ 92392	_____
❑ Permanent	❑ Temporary		
❑ Repair/Alignment of Spectacles	❑ V2030	❑ 92370	_____
❑ Roll and Polish		_____	_____
❑ Frame	❑ V2020	❑ 92390	_____
❑ Safety Prescriptions		_____	_____
❑ Side Shields		_____	_____
❑ Options		_____	_____
❑ Other _____			_____
❑ Other _____			_____

CONTACT LENS SERVICES

❑ Right ❑ Left ❑ Both

❑ Aphakic 92396 ❑ Non-Aphakic 92391

				Fee
❑ Contact Lens Replacement			92326	_____
	PMMA	Gas Perm	Soft	
❑ Single Vision	❑ V2500	❑ V2510	❑ V2520	_____
❑ Astigmatism/ Toric	❑ V2501	❑ V2511	❑ V2521	_____
❑ Bifocal	❑ V2502	❑ V2512	❑ V2522	_____
❑ Extended Wear		❑ V2513	❑ V2523	_____
❑ Astig. Ext. Wear		❑ ____	❑ ____	_____
❑ Boston Kit			_____	_____
❑ Solutions/Supplies _____				_____
❑ Other _____				_____
❑ Other _____				_____

PROVIDER'S NAME

ADDRESS

CITY, STATE, ZIP

EMPLOYER/TAX ID NO. LIC. #

( )

TELEPHONE

1. Accept Assignment: ❑ Yes ❑ No
2. Was Tonometry performed? ❑ Yes ❑ No
3. Are safety glasses OSHA approved? ❑ Yes ❑ No

Professional Services	Rx #1		Rx #2 - Safety	
Frame				
Lenses				
Tint				
Oversize				
Scratch				
Material Service Fees				
Tax				
Total				

Provider's Signature _____ Date _____

FUND OFFICE USE ONLY Exam _____ Lenses _____ Frames _____ Safety _____

Eligibility: ❑ Yes ❑ No _____ _____ _____ _____

- _____ - _____ - _____ - _____