Social Security or AID No. _____

VISION

GSA-ILA EMPLOYERS WELFARE FUND
VISION MEDICAL CARE CLAIM FORM

PHYSICIAN OR SUPPLIER

PHYSICIAN OR SUPPLIER: IT IS YOUR RESPONSIBILITY TO ENSURE THIS ENTIRE FORM IS COMPLETE AND TO SIGN WHERE INDICATED.

SECTION A. PATIENT AND EMPLOYEE (SUBSCRIBER) INFORMATION

1. Patient's Full Name (Please Print)

2. Patient's Address (Street, City, State, Zip)

3. Patient's Birthdate (Mo/Da/Yr)

4. Patient's Sex:
❑ Male ❑ Female

5. Patient's Relation to Insured
Self ❑ Spouse ❑ Child ❑ Other ❑

6. Was Condition Related to:
A. On the job injury:
❑ Yes ❑ No
Explain: _____
B. Accidental Injury:
❑ Yes ❑ No
Explain: _____
C. Auto Accident:
❑ Yes ❑ No
Explain: _____

7. Employee's Full Name (Please Print)

8. Employee's Address (Street, City, State, Zip)

9. Employee's Birthdate (Mo/Da/Yr)

10. Employee's Social Security or AID Number

11. Employee's Daytime Telephone Number

12. Other Health Care Coverage – Enter name of policyholder, Plan name, address, and policy or medical assistance number:

13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. *I Authorize the Release of any Medical Information Necessary to Process this Claim.*

SIGNED _____

DATE _____

14. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW. THIS AUTHORIZATION IS INVALID UNLESS TAXPAYER IDENTIFICATION NUMBER (TIN) OF PHYSICIAN OR SUPPLIER IS PROVIDED BELOW.

SIGNED _____

DATE _____

SECTION B. EXAMINING PHYSICIAN OR OPTOMETRIST'S INFORMATION – TO BE COMPLETED BY PHYSICIAN OR OPTOMETRIST

15. Physician or Optometrist's Full Name:

Physician or Optometrist's Address: (Street, City, State, Zip)

16. Telephone Number:

17. You are required under authority of law to enter the Taxpayer Identification Number (TIN) or the Physician or Optometrist's Social Security Number to be used for 1099 reporting purposes.

18. Title: ❑ M.D. ❑ D.O. ❑ O.D.

19. Examination Date(s) _____;
_____;
_____;

20. Has Cataract surgery been performed?
❑ Yes ❑ No

21. Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses?
❑ Yes ❑ No

22. Can visual acuity be restored to 20/70 in better eye with contacts?
❑ Yes ❑ No

23. Visual acuity corrected
From: _____ To: _____

24. Diagnostic Code(s) _____; _____;
_____; _____; _____;
_____; _____; _____;

25. Indicate diagnosis or nature of disease or injury or vision disorder (indicate procedure code numbers):

26. Does patient require a prescription change at this time?
❑ Yes ❑ No

27. Do Frames need changing?
❑ Yes ❑ No

28. If YES to **No. 27**, please give reason (i.e., lost, stolen, broken, etc…):

29. Did exam include: Tonometry?
❑ Yes ❑ No

30. What was the purpose of this examination (i.e., required by a governmental body, employment, or other purpose)?

31. Do Lenses need changing?
❑ Yes ❑ No

32. If YES to **No. 31**, please give reason (i.e., lost, stolen, broken, etc…):

33. Did exam include: Refraction?
❑ Yes ❑ No

34. Doctor's Prescription

	Sphere	Cylinder	Axis	Prism	Base
R.E.	•	•			
L.E.	•	•			
Reading Add		R.E.	+ •	L.E.	+ •

35. Professional Service — Amount

Charge for Exam (HCPC/CPT)	$
Sales Tax (if any)	$
Total	$
Amount Paid by Patient	$

COUNTY OF GLYNN)
STATE OF GEORGIA)

ACKNOWLEDGMENT

The undersigned hereby acknowledges that he/she understands that it is a crime to knowingly make false statements and representations of fact, or knowingly conceal, cover-up, or fail to disclose any required fact, in any document required by or is necessary to verify, explain, clarify or check for accuracy and completeness of any report required by the Employee Retirement Income Security Act of 1974 ("ERISA") and that any false statement or representation made in reporting may subject him/her to prosecution under 18 U.S.C. §1027, the penalty for which is a fine of $10,000.00 or imprisonment of five (5) years or both. By signing below, the undersigned further hereby acknowledges and agrees to periodic audits in reference to said claims by GSA-ILA Employers Welfare Fund auditors. I further hereby certify that the procedures or supplies as indicated above have been completed or delivered and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures or supplies.

(Name of Physician)_____ (Date) _____ (Signature of Physician) **X** _____

Rev. 05-23-12

Social Security or AID No. _____

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SECTION C. SUPPLIER'S INFORMATION – TO BE COMPLETED BY SUPPLIER.

36. Supplier's Name	Supplier's Address: (Street, City, State, Zip)

37. Telephone Number:	**38.** You are required under authority of law to enter the Taxpayer Identification Number (TIN) or the Physician or Supplier's Social Security Number to be used for 1099 reporting purposes:

39. Title	**40.** Date	**41.** Materials Supplied		
		❑ Glass Lenses	❑ Plastic Lenses	❑ Tint: _____
❑ Optician ❑ Optometrist	❑ Order _____	❑ Photosensitive	❑ Anti-reflective	❑ Other: _____
❑ Ophthalmologist	❑ Delivery_____			_____

42. If contact lenses, please complete:

❑ Therapeutic (HCPC/CPT)	❑ Non-Therapeutic (HCPC/CPT)	❑ Hard Lenses (HCPC/CPT)	❑ Soft Lenses (HCPC/CPT)	❑ Quantity of contact lenses:

43. The following Lenses and/or Frames were ordered on _____ Mo/Da/Yr) for the above patient as prescribed on _____ (Mo/Da/Yr) by myself or Dr. _____.

44. Type of lenses dispensed	Number of Lenses:	Amount Charged	Extra Charge for Photosensitive or Anti-reflective
❑ None		$	$
❑ Single (HCPC/CPT)		$	$
❑ Bifocal (HCPC/CPT)		$	$
❑ Trifocal (HCPC/CPT)		$	$
❑ Lenticular(HCPC/CPT)		$	$
❑ Contacts (HCPC/CPT)		$	$
❑ Sunglasses (HCPC/CPT)		$	$
❑ Tint No.		$	$
❑ Other (HCPC/CPT)		$	$
	TOTAL LENS CHARGE	$	$
	FRAMES CHARGE	$	$
	AMOUNT PAID BY PATIENT	$	$
	BALANCE DUE	$	$

45. List any other information relevant to this claim, including but not limited to the brand name and general description of the product:

COUNTY OF GLYNN) ***ACKNOWLEDGMENT***
STATE OF GEORGIA)

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(Name of Supplier)_____ (Date) _____ (Signature of Supplier) **X** _____

Please file claim with:

Mailing Address:
ILA1423
1403 Fourth Ave
Brunswick, Georgia 31525