MAIL COMPLETED FORM TO:
FITZHARRIS & COMPANY, INC.
PO BOX 9182
FARMINGDALE, N.Y. 11735
(516) 777-2244 * FAX: (516) 777 777/ 78

VISION CARE
STATEMENT OF CLAIM

PART 1 TO BE COMPLETED BY EMPLOYEE/MEMBER

1.Patient Name:	2.Relationship to Member: ☐ self ☐ spouse ☐ child ☐ other	3.Sex: M F	4.Patient Birthdate: Mo Day Year	5.Patient if full time student: School: City:
6.Member Birthdate:	7.Marital Status: ☐ married ☐ single ☐ divorced ☐ widowed	8.Spouse's Name:	9.Spouse's Birthdate: Mo Day Year	10.Spouse's Soc. Sec. #:
11.Insured Name (first,middle,last):		12.Member Soc. Sec. #:	13.Group Name: CCTA Benefit Trust #0713	
14.Mailing Address:		15.Other Family Members Employed?: ☐ yes ☐ no If yes indicate: Name: Soc. Sec. #:		
City, State, Zip:				
17.Is patient covered by another plan? ☐ yes ☐ no	Plan Name:	Union Local:	Group #:	Carrier Name/Address:

TO: All providers of medical services and supplies, employers, insurance institutions and other organizations. I authorize release to Fitzharris & Co., my employer or other representative any information, including medical, employment and benefit information required for claim processing or plan administration. This authorization is valid for one year after the date signed. A copy of this authorization shall be as valid as the original. I understand that I may request a copy of this authorization.

Benefits assigned to provider of services: ☐ yes ☐ no

Any person who knowingly, and with intent to defraud any fund or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulant insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF ELIGIBLE MEMBER:_____ DATE:_____

PART 2 TO BE COMPLETED BY OPTOMETRIST

1.Supplier:	7.Is treatment result of occupational illness or injury?: ☐ yes ☐ no If yes, enter brief description & dates:
2.Mailing Address:	8.Is treatment a result of auto accident?:
3.City, State, Zip:	9.Other accident?:
4.Soc.Sec # or T.I.N.: 5.License #: 6.Phone #:	10. Are any services covered by another plan?:

11.Description of services	Date of sevice	Fee
A. Examination		
B. Single Vision w/Frame		
C. Bifocal w/ Frame		
D. Frame Only		
E. Tint		

11.Description of services	Date of sevice	Fee
F. Lenses Only 1.single vision		
2. Bifocal		
G. Contact Lenses		
H. Other		
I. Total charges		

12.PLEASE COMPLETE THE FOLLOWING:

A. Were lenses prescribed as a result of eye surgery? yes_____ no_____

If yes, please specify procedure: _____

_____

B. What is patients present degree of visual acuity?

corrected _____ uncorrected_____

C. Indicate Diagnosis or nature of disease or visual disorder _____

D. If tinted glasses were furnished, were they specifically supplied for medical reasons? Yes_____ No_____

E. Please sign below:
Signature:_____ Date:_____

PART 3 EMPLOYER/PLAN ADMINISTRATOR

Member:	Member ID #:	Group Name:	Policy #:	Division:
Date Benefits Became effective: Month Day Year Month Day Year EMP DEP	Date Terminated: Mo Day Yr	Authorized Signature:		Date:

Plan Administrator Copy