PORT JERVIS TEACHERS' ASSOCIATION
BENEFIT FUND OFFICE
P. O. Box 95
Port Jervis, New York 12771

VISION CARE CLAIM FORM

Vision Care Provider: Complete the Provider section of this form **or** attach a statement containing the same information, certification, and dated signature. Return this form to the patient with a receipt for the payment made.
Covered charges shall consist of charges incurred by the member and/or his/her dependents while coverage is in effect for the following: eye exams performed by a licensed optometrist or physician in the specialty of the eye and eyeglass frames, lenses, and contact lenses prescribed by such practitioner; LASIK surgery performed by a physician accredited in the specialty of the eye. No **coverage is provided for non-prescription glasses and/or sunglasses, taxes, postage, shipping, handling, warranties, insurance plans, protection plans, and other fees.**

DATES OF SERVICE	MATERIALS AND/OR SERVICES PROVIDED	FEES CHARGED
_____	_____	_____
_____	_____	_____
_____	_____	_____

Provider's Certification: I certify that the materials/services listed above were provided on the dates indicated and that the fees listed are the actual fees that I have charged and have collected for the listed materials and/or services for

_____
(**Patient**'s Last Name, First Name, and Middle Initial)

_____ _____
(Vision Care Provider's Signature) (Date Signed)

Benefit Fund Member: Have the vision care provider complete the Provider section of this form and give you a receipt for the payment made to the vision care provider. Then, complete the Member Certification section of this form, **attach the receipt for the payment made to the vision care provider,** and mail this claim form and the receipt to the PJTA Benefit Fund Office within 90 days of the completion of services. If applicable, the Patient section of this form must also be completed.

Member's Certification: I certify that the information given is correct, and to the extent permitted under applicable law. I authorize the release of any information necessary to process this claim.

_____ _____
(Member's Signature) (Date Signed)

_____ _____
(Member's Last Name, First Name) (Member's Address)

Patient (if not the member): I certify that the information given is correct, and to the extent permitted under applicable law. I authorize the release of any information necessary to process this claim.

Relationship to Member: ☐ Spouse ☐ Child ☐ Other

Is patient covered by another plan? ☐ Yes ☐ No **If yes, attach a copy of the Explanation of Benefits paid by the other plan.**

_____ _____
(Patient or Guardian's Signature) (Date Signed)

_____
(Patient's Last Name, First Name, and Middle Initial)

FOR PJTA BENEFIT FUND OFFICE USE ONLY

Plan Year: July 1, _____ - June 30, _____ Date Paid: _____ Check #: _____ Amount: $_____ 7/2020