LOCAL 1181 A.T.U.

c/o Vision Screening, Inc.
1919 Middle Country Road
Centereach, NY 11720

EYE CARE REIMBURSEMENT PROGRAM

TO BE COMPLETED BY OPTOMETRIST - OPTICIAN OR OPHTHALMOLOGIST

Member's Name _____ **S.S.#** _____-____-_____

Address _____

Patient Name & Relationship _____

BILLS FOR EXAMINATION, EYE GLASSES AND/OR CONTACTS MUST BE ATTACHED.

Examination	**$**_____	
Single Vision Lenses	**$**_____	
Bifocal Vision Lenses	**$** _____	
Trifocal Vision Lenses	**$** _____	**EXAMINER**
Frame	**$** _____	**Name:** _____
		Phone: _____
Contact Lenses	**$** _____	
Total Charges	**$** _____	**Date of Service:** _____

Authorization to release information - I hereby authorize any provider, insurer or other organization to release any information regarding the history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

Members Signature _____ **Date** _____