VISION PLAN BENEFITS

I.B.U. NATIONAL HEALTH BENEFIT PLAN PMB
#116 · 5331 S Macadam Avenue Suite 258
Portland, OR 97239
Portland Area: (503) 224-0048
All Other Locations: (800) 547-4457

PART 1: MUST BE COMPLETED BY EMPLOYEE

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. EMPLOYEE'S NAME, ADDRESS AND PHONE NO.

FULL TIME STUDENT
☐ YES ☐ NO IF YES, WHERE

4. PATIENT'S ADDRESS *(If different from employee)*

5. PATIENT'S SEX
MALE ☐ ☐ FEMALE

6. EMPLOYEE'S SOC. SEC. NO.

7. PATIENT'S RELATIONSHIP
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. EMPLOYER LOCATION

9. IS PATIENT ALSO COVERED BY ANOTHER GROUP HEALTH PLAN? ☐ Yes ☐ No
If Yes, List Plan Name, Employer and Address

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
YES ☐ ☐ NO
B. AN ACCIDENT
YES ☐ ☐ NO

11. IF AN ACCIDENT ☐ A.M. ☐ P.M.
date _____ 19____ and time _____
description (how & where)_____

12. AUTHORIZATION TO RELEASE INFORMATION

PATIENT OR PARENT PLEASE SIGN BELOW
I hereby authorize any insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

X_____
PATIENT OR PARENT (IF MINOR) DATE

13. AUTHORIZATION TO PAY BENEFITS TO PROVIDERS

IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW
I hereby authorize payment of benefits directly to any providers of services, but not to exceed the usual, reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X_____
EMPLOYEE DATE

14. AUTHORIZATION TO PAY BENEFITS TO SUPPLIERS

I hereby authorize payment of benefits directly to the undersigned supplier for services described in Part 3 below, but not to exceed the usual, reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X_____
EMPLOYEE DATE

PART 2: TO BE COMPLETED BY PHYSICIAN OR OPTOMETRIST (OR ATTACH ITEMIZED BILL)

Indicate diagnosis or nature of disease or injury or vision disorder.

PRESCRIPTION	SPHERE	CYLINDER	AXIS	PRISM	ADD FOR READING
RIGHT					
LEFT					

DID PATIENT HAVE EYEGLASSES PRIOR TO THE DATE OF YOUR EXAMINATION? YES ☐ ☐ NO

IF "YES", IS PRESCRIPTION FOR NEW LENSES DIFFERENT FROM THAT OF LENSES BEING REPLACED? YES ☐ ☐ NO

STATE ANY SPECIAL REQUIREMENTS SUCH AS TINTING, CONTACT LENSES, ETC., INCLUDING REASON.

REPORT OF SERVICES (OR ATTACH AN ITEMIZED BILL) DATE OF SERVICE	SERVICES RENDERED	REFRACTION INCLUDED	CHARGE
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	

PHYSICIAN'S OR OPTOMETRIST'S NAME, ADDRESS & ZIP CODE
☐ OPHTHALMOLOGIST ☐ OPTOMETRIST

TOTAL CHARGE

TELEPHONE NO.

YOUR SOCIAL SECURITY NO.

SIGNATURE OF PHYSICIAN OR OPTOMETRIST

DATE SIGNED

YOUR EMPLOYER I.D. NO.

PART 3: TO BE COMPLETED BY SUPPLIER, DISPENSER OF PRESCRIPTION (OR ATTACH ITEMIZED BILL)

LENSES FOR ☐ ONE EYE ☐ BOTH EYES

DATE MATERIAL ORDERED_____

CHARGES:
SINGLE VISION $_____ BIFOCAL $_____ TRIFOCAL $_____
LENTICULAR $_____ CONTACT $_____ FRAMES $_____
APHAKIC LENSES $_____ OTHER_____ $_____

DESCRIBE AND INDICATE ADDITIONAL CHARGES FOR SPECIAL FEATURES SUCH AS HARDENING, TINTING, LENSES IN EXCESS OF 54 MILLIMETERS, ETC.

ARE EXISTING FRAMES BEING USED FOR THE NEW LENSES? ☐ YES ☐ NO

IF "NO", WHY?_____

SUPPLIER'S NAME, ADDRESS & ZIP CODE
☐ OPTHALMOLOGIST ☐ OPTOMETRIST ☐ OPTICIAN

TELEPHONE NO.

YOUR SOCIAL SECURITY NO.

SIGNATURE OF SUPPLIER

DATE SIGNED

YOUR EMPLOYER I.D. NO.

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HOW TO REQUEST BENEFITS

1. CLAIM FORMS ARE AVAILABLE IN YOUR PERSONNEL OFFICE.
2. COMPLETE THE "PATIENT INFORMATION" (ITEMS 1 THROUGH 12) ON THE REVERSE SIDE OF THIS FORM.

   If you wish your benefits paid directly to your physician or optometrist, sign item 13. If you wish benefits paid directly to the provider of materials, sign item 14.
3. HAVE YOUR OPHTHALMOLOGIST OR OPTOMETRIST COMPLETE THE "PHYSICIAN OR SUPPLIER INFORMATION" PART 2 AND PART 3.
4. ATTACH THE COMPLETED "BENEFIT REQUEST FORM" TO THE BILLS AND MAIL THEM TO THE PLAN ADMINISTRATOR AT THE FOLLOWING ADDRESS.
5. A SEPARATE FORM MUST BE SUBMITTED FOR EACH FAMILY MEMBER FOR WHOM A CLAIM FOR BENEFITS IS BEING MADE.

WHERE TO FILE A CLAIM:

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CHECK YOUR ELIGIBILITY — CALL THE ADMINISTRATION OFFICE
In Portland Area (503) 224-0048
ALL OTHER LOCATIONS 1-800-547-4457

SEE OTHER SIDE