

# Arizona Pipe Trades Health & Welfare Fund

## Active Employees Vision Reimbursement Claim Form

P.O. Box 4660  
Troy, MI 48099-4660  
Phone: (877) 429-7473 Option 3 Fax: (248) 556-2597

- ✓ What is reimbursable? Vision charges
- ✓ Who is eligible? Active Employees and their eligible dependents
  - Please submit the itemized bill or receipt for vision charges (must include a description of the expenses, dates of service and procedure codes).
  - Active Vision Coverage - Vision care expenses are payable at 80% up to a maximum of \$500.00 per person per calendar year effective 9/1/19.
  - Active Employees Only – Prescription Safety Glasses/Goggles expenses are payable at 80% up to a maximum of \$200 every 24 months.
  - This Vision reimbursement is not available for a non-COBRA Active Employee that has elected to continue eligibility for himself or herself and his/her eligible Dependents on a self-payment basis.

Member's Name: \_\_\_\_\_

Member's DOB: \_\_\_\_\_ Alt ID or Last 4 SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Tax Id: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Provider's Phone #: \_\_\_\_\_

Benefit Description: (*circle one*)      **Active Vision**      **Active Safety Glasses/Goggles**

Date of Service	Provider	Billed Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_