## Vision Care Plan • Statement of Claim ALL INFORMATION MUST BE COMPLETED ON THIS FORM

## INSTRUCTIONS:

- Employee completes Part 1 of this form.
- Your optometrist, ophthalmologist, or optician completes Part 2 of this form.
- A separate Claim Form is required for each family member.
- 4. One Claim Form is to be used for all services.
- 5. PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS
  TO SUBMIT YOUR CLAIM FORM TO VBA: 1) MAIL OR FAX TO THE
  ADDRESS AND/OR NUMBER LISTED BELOW OR COMPLETE THE
  EDITABLE FORM AND UPLOAD YOUR RECEIPTS ON OUR WEBSITE,
  VBAPLANS.COM WITHIN 180 DAYS FROM THE DATE OF SERVICE.

If you have any questions regarding the completion of this form, please contact your Personnel Office or Health & Welfare office.

PART 1 To be completed by Employee	(please print or type)	Residence in the	
EMPLOYEE'S FULL NAME (LAST, FIRST, MIDDLE)		SOCIAL SECURITY NUMBER	VBA CO# #652 Midwestern PA School EE Benefits Consortium
HOME ADDRESS		CITY STATE ZIP	
PATIENT'S FULL NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO EMPLOYEE	BIRTHDATE	
	SELF - SPOUSE - CHILD -		
THIS CLAIM IS NOT FOR TREATMENT OF AN O NECESSARY INFORMATION TO THIS CLAIM I		THORIZE ANY OF THE UNDERS	IGNED TO DISCLOSE ANY
MEMBER/EMPLOYEE SIGNATURE		DATE	

## USE ONE FORM FOR EACH BENEFICIARY

PRACTICE NAME  OD MD  ADDRESS  DID YOU PRESCRIBE? YES DOD DID YOU PRESCRIBE? YES DOD DID TONOMETRY DATE OF EXAM  EXAM CHARGE S  CITY  STATE  ZIP CODE  EXAMINING DOCTOR  SIGNATURE  DATE  TELEPHONE NUMBER (INCLUDE AREA CODE)  DISPENSING PRACTICE NAME IF DIFFERENT FROM EXAMINING FRACTICE  DATE DIRECTLY  STATE  ZIP CODE  SINGLE VISION  S  GITY  STATE  ZIP CODE  BIFOCAL  TELEPHONE NUMBER (INCLUDE AREA CODE)  DISPENSING DOCTORIOPTICIAN  SIGNATURE  DATE  DATE  TOTAL CHARGE  S  TOTAL CHARGE  TOTAL CHARGE  S  TOTAL CHARGE  TOTAL CHARGE  S  TOTAL CHARGE  TOTAL CHARGE  S  TOTAL CHARGE  TOTA		ometrist, ophthalmologist or opticia					
OD MD  ADDRESS  DID YOU PRESCRIBE? YES NO D  STATE ZIP CODE  EXAMINING DOCTOR SIGNATURE  DATE  D	PRACTICE NAME	CIRCLE ONE	PLEASE MARK THE SERVICE FOR THE TYPE OF EXAM PERFORMED				
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				TOTAL CHAR			

ATTACH YOUR RECEIPTS TO THIS CLAIM FORM AND MAIL / FAX / UPLOAD TO: VISION BENEFITS OF AMERICA