Vision Care Plan • Statement of Claim

ALL INFORMATION MUST BE COMPLETED ON THIS FORM

INSTRUCTIONS:

1. Employee completes Part 1 of this form.
2. Your optometrist, ophthalmologist, or optician completes Part 2 of this form.
3. 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)

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 SELF ☐ SPOUSE ☐ CHILD ☐	BIRTHDATE	

THIS CLAIM IS NOT FOR TREATMENT OF AN OCCUPATIONAL ACCIDENT AND I HEREBY AUTHORIZE ANY OF THE UNDERSIGNED TO DISCLOSE ANY NECESSARY INFORMATION TO THIS CLAIM I CERTIFY TO THESE STATEMENTS

MEMBER/EMPLOYEE SIGNATURE DATE

USE ONE FORM FOR EACH BENEFICIARY

PART 2 To be completed by optometrist, ophthalmologist or optician (please print or type)

EXAM	PRACTICE NAME CIRCLE ONE OD MD		PLEASE MARK THE SERVICE FOR THE TYPE OF EXAM PERFORMED VISION ANALYSIS ☐ TONOMETRY ☐	
	ADDRESS		DID YOU PRESCRIBE? YES ☐ NO ☐	DATE OF EXAM EXAM CHARGE $
	CITY STATE ZIP CODE		EXAMINING DOCTOR SIGNATURE DATE	
	TELEPHONE NUMBER (INCLUDE AREA CODE)			
LENSES	DISPENSING PRACTICE NAME IF DIFFERENT FROM EXAMINING PRACTICE		DATE ORDERED	
	ADDRESS		PLEASE INDICATE SEPARATE BASIC LENS CHARGE SINGLE VISION $_____ BIFOCAL $_____ TRIFOCAL $_____ LENTICULAR $_____ ELECTIVE CONTACTS $_____ MEDICAL REQ'D CONTACTS $_____	
	CITY STATE ZIP CODE			
	TELEPHONE NUMBER (INCLUDE AREA CODE)			
	DISPENSING DOCTOR/OPTICIAN SIGNATURE DATE			
FRAME	IF A NEW FRAME IS SUPPLIED, PLEASE INDICATE CHARGE		$_____ TOTAL CHARGE $_____	

ATTACH YOUR RECEIPTS TO THIS CLAIM FORM AND MAIL / FAX / UPLOAD TO:

VISION BENEFITS OF AMERICA
400 LYDIA STREET
CARNEGIE PA 15106
FAX: 412-881-4898
VBAPLANS.COM