



VISION CLAIM FORM

INSTRUCTIONS

- Employee should complete Part 1.
 - Physician should complete Part 2.
 - Completed form should be mailed to:
- TPSC Benefits Claims Administrator:**
P.O. Box 2950; Tacoma, WA 98401
Phone: 253.564.5611 ext. 210
Fax: 253.564.5881
Toll Free: 800.426.9786 ext. 210

PART 1: TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)

Last Name:		First Name:		M.I.:
Birth Date:		Social Security #:		
Address:			<input type="checkbox"/> Check If New Address	
City:	State:	Zip:	Phone #:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Claim is made for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Name of Employer:			Group #:	
Person receiving vision care: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth of person receiving vision care:		
Name of person receiving vision care:				
Does claimant have vision benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name of any other insurance carrier or organization providing benefits for vision care: <i>(Including dependent insurance)</i>				
Was vision care required because of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "yes" complete below)</i>				
Was injury caused by your work? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you filed a claim for this disability with the worker's compensation carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is vision examination required as a condition of your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No				

**THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF.
I HEREBY AUTHORIZE MY DOCTOR TO FURNISH AND DISCLOSE ALL FACTS CONCERNING THIS DISABILITY.**

Signature

Date

**I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED
PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW.**

Signed
(Insured or authorized person)



VISION CLAIM FORM

PART 2: TO BE COMPLETED BY DOCTOR

Physician Name: *(M.D., O.D. or Dispensing Optician)*

Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____

Physician IRS Tax #: _____ Physician Signature: _____ Date: _____

Has patient worn glasses before this examination? Yes No Type: _____

If "yes", state reason for replacement: _____

If you prescribed glasses, check type: Single vision Bifocal Trifocal Other *(describe)*

Has cataract surgery been performed? Yes No Date: _____

Can visual acuity be restored to at least 20/70 in the better eye with conventional glasses? Yes No

Are existing frames being used for the new glasses? Yes No

If "no", why not?: _____

Professional Services	CPT	Date	Charge	Professional Services	CPT	Date	Charge
Vision Survey				Contacts, Each Lens			
Visual Exam W/O Tonom				Frame Service			
Visual Exam W/ Tonom				Other			
Single Vision Lenses				Other			
Bifocal Lenses							
Trifocal Lenses							
Lenticular Lenses							