DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

125 Barclay Street, New York, N.Y. 10007 (212) 815-1234

CLAIM FOR DIRECT OPTICAL REMBURSEMENT

PLEASE READ CAREFULLY: ***Claims filed later than 30 days from date of service will be declared ineligible.***

The Optical Benefit provides three types of services once in a two-year period for eligible members and their dependents: eye examination, and/or frames, and/or lenses.

THE TOTAL OPTICAL BENEFIT (ALL THREE TYPES OF SERVICES) MUST BE SUBMITTED AT THE SAME TIME BY EACH COVERED PERSON. (This rule applies to usage by an individual. It does not mean, for example, that all covered members in a family must use the benefit at one time.)

When sumbitting Direct Reimbursement, all three types of services must be listed on the same form. If only part of the benefit is obtained and submitted for Direct Reimbursement, the part not utilized at the time of the first submission cannot be submitted within the same two years.

The benefit cannot be split between the Optical Voucher and Direct Reimbursement.

EMPLOYEE

THIS SECTION IS FOR EMPLOYEE INFORMATION. PLEASE PRINT CLEARLY.

Social Security Number	Last Name	First Name

Number and Street Address	City and State

Apt. No. or Care-of Address	Zip Code	(Area Code) Business Phone	(Area Code) Home Phone

Dept. or Instit.	Job Title	Date of Employment

PATIENT

FIRST NAME

☐ EMPLOYEE ☐ SPOUSE ☐ CHILD AGE______

☐ If student over 19, submit written proof of attendance at school

Name of spouse's employer ______

Name & address of spouse's insurance carrier ______

If cataract lenses are claimed, enter: Month/year of surgery: ____/____

Member's Signature ______ Date ______

Surgeon's name: ______ Hospital name: ______

PROVIDER

THIS SECTION IS FOR PROVIDER INFORMATION

SERVICES:
Please complete the requested and applicable information.

TYPE OF SERVICE	Please Check	CHARGES
Eye Examination	☐	$
Frames	☐	$
Single Vision Lenses	☐	$
Bifocal Lenses	☐	$
Trifocal Lenses	☐	$
Contact Lenses	☐	$
Cataract Single Vision Lenses	☐	$
Cataract Bifocal Lenses	☐	$
Cataract Contact Lenses	☐	$
Total		$

EXAMINER

Name ______

Address ______

Telephone No. ______

Date of Services ______

DISPENSER

Name ______

Address ______

Telephone No. ______

Date of Services ______

DC 37

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Group No. ____ Amount ____ Claim Examiner ____ DC 37 Authorization ____ Date ____

HS:OP 007 (REV. 6/87)

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