

Return This Completed Form To:  
**IRON WORKERS BENEFIT TRUST**  
 MAIN P.O. BOX 398  
 DAYTON, OHIO 45401-0398

# VISION CLAIM FORM



Insurance Verification:  
 Dayton 1-937-454-1744  
 Toll Free 1-800-331-4277  
 (7:30 a.m. to 4:30 p.m.)

**BENEFITS ARE PAID TO THE PROVIDER UNLESS A PAID IN FULL RECEIPT IS ATTACHED TO THIS FORM**

<b>PART A - TO BE COMPLETED AND SIGNED BY IRON WORKER (Do not abbreviate address)</b>			
1. IRON WORKERS NAME (First name, middle initial, last name).	2. I.W. SOCIAL SECURITY #	3. I.W. BIRTH DATE	4. I.W. MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated
5. IRON WORKERS ADDRESS ( Street, City, State, ZIP code).	6. HOME PHONE	7. SPOUSE'S BIRTH DATE	10. PATIENT'S RELATIONSHIP TO I.W. self    spouse    child    other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	8. WORK PHONE	9. LOCAL UNION #	
11. PATIENT'S NAME (First name, middle initial, last name).	12. PATIENT'S SOCIAL SECURITY #	13. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	14. PATIENT'S DATE OF BIRTH    AGE
15. WERE LENSES OR FRAMES BROKEN? PLEASE EXPLAIN:		16. DOES THE PATIENT HAVE ANY OTHER VISION INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
15. TO BE SIGNED BY IRON WORKER: I HEREBY CERTIFY THAT THE STATEMENTS CONTAINED ON THIS FORM ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES NOT COVERED BY THE BENEFIT TRUST.			
Iron Workers Signature:		Date Signed:	

<b>PART B - TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST (M.D.) OR OPTOMETRIST (O.D.)</b>		
NAME OF PATIENT (Please Print)	BIRTHDAY OF PATIENT (Mo.-Day-Year)	
DATE OF EXAMINATION (Mo.-Day-Year)	EXAMINATION MUST INCLUDE REFRACTION. DID IT? <input type="checkbox"/> YES <input type="checkbox"/> NO	CHARGE FOR EXAMINATION \$
DIAGNOSIS	REMARKS:	
DOCTOR'S NAME (Please Print)		DEGREE
DOCTOR'S ADDRESS		TELEPHONE #
CITY	STATE	ZIP
DOCTOR'S SIGNATURE		TAX ID #

<b>PART C - TO BE COMPLETED BY SUPPLIER OF LENSES AND/OR FRAMES</b>				
NAME OF PERSON FOR WHOM SERVICES WERE RENDERED ( Please Print)				
DATE SERVICES PROVIDED (Mo.-Day-Year)			REMARKS:	
LENSES - CONTACTS <input type="checkbox"/> YES <input type="checkbox"/> NO	SINGLE VISION <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	BIFOCAL <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	TRIFOCAL <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	CHARGE FOR LENSES \$
FRAMES: TYPE OF FRAMES SUPPLIED				CHARGE FOR FRAME \$
OFFICIAL AGENCY NAME (Please Print)			SIGNATURE OF SUPPLIER	
ADDRESS			AND TITLE	
CITY	STATE	ZIP	TAX ID #	