CLAIM FORM FOR DIRECT OPTICAL REIMBURSEMENT
PSC-CUNY WELFARE FUND

61 Broadway, 15th Floor
New York, NY 10006
(212) 354-5230

Please read carefully before completing forms:

Claims submitted later than 90 days from date of service will not be honored.

You will be reimbursed no more than once every 24 months under this program. The 24 month period is measured from the date of the most recent optical service you received. You will not be reimbursed for more than the actual cost of the covered items up to the current maximum.

Please PRINT CLEARLY. Enter all information accurately. Errors will cause delay in the processing of your claim.

Have your optician, optometrist or physician complete Part II.

PART I–TO BE COMPLETED BY WELFARE FUND MEMBER–PLEASE PRINT–ANSWER ALL QUESTIONS

MEMBER

Last Name ______________________ First Name ______________________

Street Address ______________________

City, State and Zip code ______________________

Member's Soc. Sec. No. __ __ __- __ __- __ __ __ __ Member's Sex: ❑Male ❑Female

Member's College ______________________

Member's Status: ❑Active ❑Retiree ❑Leave of Absence ❑Cobra ❑Survivors

Are other family members employed? ❑Yes ❑No If yes ______________ (Employee Name) Soc. Sec. No ______________

Name and address of employer ______________________

Is patient covered for eyeglasses by another plan? ❑Yes ❑No If yes, give ______________ (Group Name)

______________ (Union Local) ______________ (Name and address of Provider of Benefits)

The eyeglasses are for my eligible dependent. Name ______________ ❑Spouse/Dom. Partner ❑Child

Date ______________ Signature of Eligible Member ______________

PART II-TO BE COMPLETED BY OPTICIAN, OPTOMETRIST OR PHYSICIAN

OPTICIAN / OPTOMETRIST / PHYSICIAN

Name of optician,
optometrist or physician ______________________ License No. ______________

Street Address ______________________

City, State and Zip Code ______________________

Telephone No. ( ) ______________

Name of Patient ______________________

Type of Service	Charges	Type of Service	Charges
[ ] Single Vision	______	[ ] Prescription Sunglasses	______
[ ] Bifocal	______	[ ] Cosmetic Tints	______
[ ] No Line Bifocal	______	[ ] Frames	______
[ ] Trifocal	______	[ ] Other	______
[ ] Hard or Soft Contact	______	TOTAL CHARGES	$______

I am a legally qualified ❑Optician ❑Optometrist ❑Physician

I hereby certify that the information contained in this PART II is correct and that the total charge as indicated has been paid in full.

Date ______________ Signature of ______________________ (Optician/Optometrist/Physician)

SEND COMPLETED FORM TO: **PSC-CUNY WELFARE FUND**
61 BROADWAY, 15TH FLOOR
NEW YORK, NY 10006

PSC/CUNY WELFARE FUND

Date of Last
Optical Benefit ______________ Claim Examiner ______________ Date ______________

Amount of
Check ______________ Check
Number ______________ Date ______________ Authorized
Signature ______________