CENTRAL TEXAS HEALTH AND BENEFIT TRUST FUND

SOUTHWEST SERVICE ADMINISTRATORS, INC.
6121 INDIAN SCHOOL RD NE, SUITE 123
ALBUQUERQUE, NM 87110
TOLL FREE: (800) 432-6636 FAX: (505) 266-9358
WWW.SSATPA.COM

VISION BENEFIT REIMBURSEMENT CLAIM FORM

PLEASE BE AS THOROUGH AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS FORM. ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

a) EMPLOYEE INFORMATION

1.LAST NAME:	2.FIRST NAME:	3.MI:	4.GENDER:
			□ M □ F

5.BIRTH DATE:	6. SOCIAL SECURITY NO. *	7. PHONE NO.
/ /	/ /	( ) -

8.ADDRESS	CITY	STATE	ZIP

b) PATIENT INFORMATION

1.LAST NAME:	2.FIRST NAME:	3.MI:	4.GENDER:	5.BIRTH DATE:
			□ M □ F	/ /

6.RELATIONSHIP TO EMPLOYEE:

□ SELF □ SPOUSE □ CHILD □ OTHER:_____

c) CLAIM INFORMATION

1.PROVIDER NAME:	2: PROVIDER TAX ID#:	3: PROVIDER NPI #:	4. PROVIDER PHONE NO:	5.DATE OF SERVICE:

4.TYPE OF LENSES DISPENSED: *A COPY OF YOUR ITEMIZED RECEIPT(S) OR SUPER BILL MAY BE SUBMITTED IN LIEU OF COMPLETING THE BELOW*	5. BILLED CHARGES (DOLLAR AMOUNTS MUST MATCH ATTACHED RECEIPTS)
☐ NONE	EXAM: $ |
☐ SINGLE (CPT CODE)_____$_____	FRAME: $ |
☐ BIFOCAL (CPT CODE)_____$_____	LENS: $ |
☐ TRIFOCAL (CPT CODE)_____$_____	LENS TINTS/COATINGS: $ |
☐ TRANSITION (CPT CODE) _____$_____	CONTACTS: $ |
☐ LENTICULAR (CPT CODE)_____$_____	LASIK $ |
☐ CONTACTS (CPT CODE)_____$_____	TAX: $ |
☐ FRAMES (CPT CODE)_____$_____	TOTAL PAID: $ |
☐ OTHER (SPECIFY BELOW)	
(CPT CODE) _____	

Provider's Address:

Provider's Signature: **Date:**

✓_____ _____

EMPLOYEE SIGNATURE DATE

* INCLUDE YOUR RECEIPTS WITH THIS CLAIM FORM