SHEET METAL WORKERS LOCAL 49 FAMILY HEALTH PLAN

SOUTHWEST SERVICE ADMINISTRATORS, INC.
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ALBUQUERQUE, NM 87110
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VISION BENEFITS 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