Insulators and Allied Workers National Medical Fund
2010 N.W. 150th Avenue, Suite 200 | Pembroke Pines, FL 33028
Toll Free: (888) 352.0629 | West Coast Toll Free: (888) 987.0629
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Administered by: NEBA

VISION CARE CLAIM FORM

THE BENEFIT ALLOWANCE WILL BE PAID TO THE PARTICIPANT ONLY

Participant Name:			
SS# (last 4) or Alt ID:		**Local:**	
Patient Name:		**Date of Birth:**	
Address:			
City, State, Zip:		**Telephone Number:**	
Was injury or illness (if any) due to your occupation:		☐ YES ☐ NO	
Do you have any other insurance coverage:		☐ YES ☐ NO	
If yes, name of insured:			
Name of Insurance Company:		**Policy Number:**	

TO BE SIGNED BY PARTICIPANT:

The undersigned employee certifies that the above information is true and correct and the below services and materials were rendered and supplied as indicated. The undersigned also agrees to pay the doctor for the below services and materials. I hereby authorize the doctor to release the information requested on this form.

_____ _____
Participant Signature Date

TO BE COMPLETED BY DOCTOR:

Examination Fee:		**Ophthalmic Materials:**	
Lenses:		**Date of Examination:**	
Patient Name:			
Doctor's Name:			
Address of Doctor:			
City, State, Zip:			

_____ _____
Signature of Doctor Federal Tax ID #