CARPENTERS BENEFIT FUNDS OF PHILADELPHIA

WORK BENEFITS ALL

Direct Reimbursement for Vision Benefits

Please attach any paid receipts. You may also upload your form and receipt using the Benefit Fund's website www.carpenters.fund. Please complete **all** applicable sections.

Active Member Information

First Name	MI.	Last Name	D.O.B	Last 4 of SSN or UBC#

Street Address	City	State	Zip Code

Patient Information

Patient Name	Patient Date of Birth	Check One
		☐ Member ☐ Spouse ☐ Child

Other Vision Coverage (Please attach Explanation of Benefits)

Claim Information

Date of Service: _____ Diagnosis: _____

Routine Eye Exam	Frames	Single Lenses
$	$	$

Bifocal Lenses	Trifocal Lenses	Progressive Lenses	Contacts
$	$	$	$

The following services are not covered:

- Medical problem with eye (goes to Blue Cross)
- 2nd pair of glasses (Except Philadelphia Eyeglass Lab)
- Contact Lens Fitting Fitting/Consultation
- Sunglasses
- Tint or Polish
- Anti-Reflective
- Scratch Resistant
- Ultra Violet
- Visual Field Exam/Fundus Photo
- Polycarbonate (Lumped in with Lenses)

However, these items can be reimbursed through the Fund's Health Reimbursement Account (HRA)

Participant Statement:

I certify that the information on this form is correct and I authorize the Provider to release all appropriate information necessary to process this claim to plan provisions

x_____ _____

Signature of Participant **Date**