Painters & Allied Trades District Council #82 Health Care Plan

VISION REIMBURSEMENT CLAIM FORM

The following information must be completed by the Participant/Policyholder. Once completed, return the form to the address listed at the bottom of this form:

1. Participant/Policyholder Information:

Name: _____
Last First MI

ID #: _____

Date of Birth: _____
Month Date Year

Address: _____
Street Address

_____
City State Zip

2. Patient Information (if same as Participant/Policyholder, print SAME):

Name: _____
Last First MI

ID #: _____

Date of Birth: _____
Month Date Year

Address: _____
Street Address

_____
City State Zip

3. Does the Patient have other vision coverage? ____Yes* _____No
**If yes, please provide a copy of the Explanation of Benefits*

4. An itemized receipt must be attached to this Vision Claim Form showing the following information:
- Provider's Name and Address
- Patient's Name
- Date, Place of Service, and Type of Service
- Itemized Charges

I hereby certify that the statements provided above, as well as the supporting documentation, are true and accurate in every way:

_____ _____
Participant Signature Date

_____
Phone Number

Return Completed Form to:
Painters and Allied Trades District Council #82 Health Care Plan
c/o Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: (952) 854-0795 |Toll Free: (800) 535-6373 | Fax: (952) 851-3569