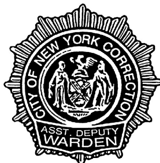
RETURN TO:
ADMINISTRATIVE SERVICES ONLY, INC.
Department 66-O
PO Box 9005
Lynbrook, NY 11563

(516) 396-5500 / (718) 204-7172



Assistant Deputy Wardens Deputy Wardens Association

☐ ACTIVE ☐ RETIREE

VISION CLAIM FORM

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name	Birthdate	Relationship to Member	Full Time College Student	School
		Spouse ☐ Child ☐	Yes ☐ No ☐	

MEMBER/EMPLOYEE INFORMATION

Member Name				Birth Date	Social Security #: (last 4 digits) XXX-XX-________
Street Address	City	State	Zip		Telephone #
Member's School or Work Location					Work Telephone #

SPOUSE INFORMATION

Spouse's Name (Print)	Birth Date	Social Security #: (last 4 digits) XXX-XX-________	Is spouse covered by another Benefits Plan? YES ☐ NO ☐
Name, Address, Telephone # of Spouse's Employer			Name of Benefit Plan
ARE ANY OTHER OPTICAL BENEFITS AVAILABLE FOR THIS PATIENT? YES ☐ NO ☐			IS THIS AN HMO PLAN? YES ☐ NO ☐

PROVIDER INFORMATION (EXAMINER)

Provider's Name (Print)	License #	Telephone #	Taxpayer ID #
Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

Certification of Examiner: I have examined the above named patient and have found the following vision defects:

Fee ($)

Signature of Examiner ______________________ Date ______________

Provider's Name (Print)	License #	Telephone #	Taxpayer ID #
Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

Was the Examination required by: AN EMPLOYER AS A CONDITION OF EMPLOYMENT? Yes ☐ No ☐ BY A GOVERNMENT BODY? Yes ☐ No ☐

SERVICE	FEE ($)	DATE	FOR OFFICE USE
FRAMES			
LENSES Single Vision			
Bifocal			
Trifocal			
Lenticular			
Contact Lenses			

Signature of Dispenser: ______________________

Date: ______________

EXAMINATION

List all tests done in conjunction with the examination:

If contact lenses were used:

	YES	NO
A. Could visual acuity of the better eye been corrected to 20/70 by use of Conventional type lens?	☐	☐
B. If "No" was it corrected to better than 20/70 by the use of contact lenses?	☐	☐
C. Did patient undergo cataract surgery?	☐	☐

If yes date: ______________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Assistant Deputy Wardens Deputy Wardens Association or its designated agent to release a// information with respect to myself or any of my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct. **Authorization must be signed or payment will not be made.**

Signed (Patient, or Parent if Minor): ______________________ **DATE:** ______________

ASSIGNMENT OF BENEFITS:

I hereby authorize payment of the benefits (otherwise payable to me) directly to the above named physician. I understand I am financially responsible for charges not covered by this authorization.

Signed (Member): ______________________ **DATE:** ______________