Plan Sponsor & Claims Administrator
Southern Tier Environments for Living, Inc.
715 Central Avenue Dunkirk, NY 14048
Tel: (716) 366-3200 Fax: (716) 366-7840

Vision Claim Form

PATIENT SECTION

1. Patient name First MI Last	2. Relationship to employee ☐self ☐child ☐spouse ☐other____________	3. Sex M F	4. Patient birthdate MM DD YYYY	5. If full time student school city
6. Employee name and mailing address	7. Employee Soc. Sec. Number	8. Employee birthdate MM DD YYYY	9. Employer (company) name and address **Southern Tier Environments for Living, Inc.** 715 Central Ave Dunkirk, NY 14048	
10. Is patient covered by another plan of benefits? Vision ______________ Medical ______________	11a. Name and address of carrier(s)	11b. Group no.(s)	12. Name and address of employer	
13a. Employee/subscriber name (if different than patient's)	13b. Employee/subscriber Soc. Sec. Number	13c. Employee/subscriber birthdate MM DD YYYY	14. Relationship to patient ☐self ☐child ☐spouse ☐other ___________	

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.
I understand that I am responsible for all costs of vision treatment.

____ _____________
Signed (Patient or parent if minor) Date

OPTICAL PROVIDER

		No	Yes	If yes, enter brief description and dates.
15. Optical Provider name	20. Is treatment result of occupational illness or Injury?			
16. Mailing address	21. Is treatment result of auto accident? 22. Other accident?			
City , State, Zip	23. Are any services covered by another plan?			
17. Telephone	24. Is any treatment/service for cosmetic purposes?			
18. First visit date current series	25. Is any treatment/service for replacement of lost, stolen, broken, or damaged lenses, contact lenses or frames?			If no, reason for replacement
19. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other _______________	26. Is any treatment/service for industrial safety glasses, goggles, or sunglasses?			

Receipts must be submitted along with claim form

VISION CARE EXPENSE ITEMIZATION

ITEMIZED BILLS WITH THE FOLLOWING INFORMATION MUST BE ENCLOSED WITH THIS FORM:

- PATIENT'S FULL NAME
- DESCRIPTION OF EACH SERVICE AND CORRECTIVE LENSES.
- DATE AND AMOUNT CHARGED FOR EACH SERVICE AND CORRECTIVE LENSES.
- NAME AND ADDRESS OF PROVIDER OF SERVICES AND CORRECTIVE LENSES.

Optical provider must indicate services provided on receipt and itemize charges below.

Services Rendered	Date of Service	Itemized Charges (enter below)	Services Rendered	Date of Service	Itemized Charges (enter below)	27. Remarks for unusual services.
Eye Exam			Trifocal			
Frames			Lenticular			
Single Vision Glasses			Contact Lenses (Optional)			
Bifocal (single)			Contact Lenses (only if vision cannot be made 20/70 or better with spectacle lenses			
Bifocal (double)						

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

____ _____________
Signed (Optical Provider) Date

Total Fee Charged	
Payment Made	
Balance due	