SHEET METAL WORKERS' LOCAL 73 WELFARE FUND

4530 ROOSEVELT ROAD
HILLSIDE, ILLINOIS 60162
PHONE (708) 449-7373

CLAIM FOR OPTICAL BENEFITS

IMPORTANT

INSTRUCTIONS FOR FILING CLAIMS:
1. COMPLETE THE TOP PORTION OF THIS PAGE.
2. HAVE YOUR OPHTHALMOLOGIST OR OPTOMETRIST COMPLETE BOTTOM PORTION.
3. **ATTACH PAID BILL FOR EXAM, LENSES AND FRAMES.**

1. MEMBER'S SOCIAL SECURITY NO. ______________________________
2. MEMBER'S NAME ______________________________
   (FIRST) (INITIAL) (LAST)

   ADDRESS ______________________________
   (STREET NUMBER) (CITY) (STATE) (ZIP CODE)

   HOME PHONE NO. ______________________________
3. PATIENT'S NAME ______________________________
   (FIRST) (INITIAL) (LAST)

   PATIENT IS: ☐ MYSELF ☐ SPOUSE ☐ CHILD PATIENT IS: ☐ MALE ☐ FEMALE

   PATIENT DATE OF BIRTH ____________ PATIENT'S SOC.SEC.NO. ____________
4. ______________________________ ____________
   MEMBER'S SIGNATURE DATE

THIS PORTION IS TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST

1. PATIENT'S NAME ______________________________ AGE ________
   (FIRST) (INITIAL) (LAST)
2. DATE OF MOST RECENT EYE EXAMINATION ______________________________
3. LENS PRESCRIPTION:

		SPHERICAL		CYLINDRICAL		AXIS	PRISM	BASE
DISTANCE	O.D.							
	O.S.							
ADD FOR NEAR	O.D.		INTER		VERTEX DISTANCE	O.D.		
	O.S.					O.S.		

4. NAME OF OPHTHALMOLOGIST OR OPTOMETRIST ______________________________

   ADDRESS ______________________________

   SIGNATURE ______________________________ DATE ____________ 20____