

# 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:

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

4. NAME OF OPHTHALMOLOGIST OR OPTOMETRIST \_\_\_\_\_

ADDRESS \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ 20\_\_\_\_