OPERATING ENGINEERS LOCAL No. 99 BENEFIT FUND
VISION SERVICE FORM

If seen by a Non-PPO Provider:
Send all claims to:
5901 Harford Road - Suite C
Baltimore, MD 21214
Info: 410-254-9595 / 1-800-367-7848

STATEMENT OF CLAIM TO BE SUBMITTED WITHIN 1 YEAR OF SERVICE

TO BE COMPLETED BY MEMBER.

1. Member's name_____ ID#: _____

2. If claim is for dependent - state name of dependent: _____
relationship: _____, age: _____.

3. Home address: _____

ABOVE ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE & BELIEF.

Signature_____ Date: _____

TO BE COMPLETED BY THE PROVIDER OF SERVICE * ALL CHARGES MUST BE ITEMIZED.

1. Patient's name: _____ Date of Birth: _____

2. Diagnosis: _____

DATE OF SERVICE	TYPE OF SERVICE	CHARGE
	EXAM	
	LENSES	
	FRAME	
	CONTACT LENS	
	OTHER	

The OEBF Vision Benefit allows a total payment of $250 EVERY 12 MONTHS for each eligible member & dependent. Please contact the Fund Office for verification of Vision Eligibility.

TOTAL CHARGED	$
TOTAL PAID	$
BALANCE DUE	$

_____ /____ / _____
PHYSICIAN'S SIGNATURE DATE TAX I.D. NUMBER

NAME & ADDRESS OF PROVIDER: _____

_____

PROVIDER'S PHONE NUMBER: _____

To be completed & signed by member if payment is to be issued to provider.

_____ /____ /____
SIGNATURE OF MEMBER DATE

To be completed & signed by member if payment is to be issued to member. (ORIGINAL PAID RECEIPT REQUIRED FOR REIMBURSEMENT)

_____ /____ /____
SIGNATURE OF MEMBER DATE