VISION CLAIM FORM

INSTRUCTIONS

- Employee should complete Part 1.
- Physician should complete Part 2.
- Completed form should be mailed to:

TPSC Benefits Claims Administrator:
P.O. Box 2950; Tacoma, WA 98401

Phone: 253.564.5611 ext. 210
Fax: 253.564.5881
Toll Free: 800.426.9786 ext. 210

PART 1: TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)

Last Name:	First Name:		M.I.:
Birth Date:	Social Security #:		
Address:		☐ Check If New Address	
City:	State:	Zip:	Phone #:
Sex: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single	Claim is made for: ☐ Self ☐ Spouse ☐ Child	
Name of Employer:		Group #:	
Person receiving vision care: ☐ Male ☐ Female	Date of birth of person receiving vision care:		
Name of person receiving vision care:			
Does claimant have vision benefits with any other carrier? ☐ Yes ☐ No			
Name of any other insurance carrier or organization providing benefits for vision care: *(Including dependent insurance)*			
Was vision care required because of injury? ☐ Yes ☐ No *(If "yes" complete below)*			
Was injury caused by your work? ☐ Yes ☐ No			
Have you filed a claim for this disability with the worker's compensation carrier? ☐ Yes ☐ No			
Is vision examination required as a condition of your employment? ☐ Yes ☐ No			

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF.
I HEREBY AUTHORIZE MY DOCTOR TO FURNISH AND DISCLOSE ALL FACTS CONCERNING THIS DISABILITY.

Signature _____ Date _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW.

Signed
(Insured or authorized person)

VISION CLAIM FORM

PART 2: TO BE COMPLETED BY DOCTOR

Physician Name: *(M.D., O.D. or Dispensing Optician)*		
Address:	City:	
State:	Zip:	Phone #:
Physician IRS Tax #:	Physician Signature:	Date:

Has patient worn glasses before this examination? ☐ Yes ☐ No	Type:
If "yes", state reason for replacement:	
If you prescribed glasses, check type: ☐ Single vision ☐ Bifocal ☐ Trifocal ☐ Other *(describe)*	
Has cataract surgery been performed? ☐ Yes ☐ No	Date:
Can visual acuity be restored to at least 20/70 in the better eye with conventional glasses? ☐ Yes ☐ No	
Are existing frames being used for the new glasses? ☐ Yes ☐ No	
If "no", why not?:	

Professional Services	CPT	Date	Charge	Professional Services	CPT	Date	Charge
Vision Survey				Contacts, Each Lens			
Visual Exame W/O Tonom				Frame Service			
Visual Exame W/ Tonom				Other			
Single Vision Lenses				Other			
Bifocal Lenses							
Trifocal Lenses							
Lenticular Lenses							