DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN
125 BARCLAY STREET, NEW YORK, N.Y. 10007 (212) 815-1234

CLAIM FOR DIRECT OPTICAL REIMBURSEMENT

PLEASE READ CAREFULLY: ***Claims filed later than 30 days from the date of service will be declared ineligible.***
The Optical Benefit provides three types of services once in a two-year period for eligible members and their dependents: eye examination, and/or frames, and/or lenses.

THE TOTAL OPTICAL BENEFIT (ALL THREE TYPES OF SERVICES) MUST BE SUBMITTED AT THE SAME TIME BY EACH COVERED PERSON
(This rule applies to usage by an individual. It does not mean, for example, that all covered members in a family must use the benefit at one time.)

When submitting Direct Reimbursement, all three types of services must be listed on the same form. If only part of the benefit is obtained and submitted for Direct Reimbursement, the part not utilized at the time of the first submission cannot be submitted within the same two years.
The benefit cannot be split between the Optical Voucher and Direct Reimbursement.

EMPLOYEE

THIS SECTION IS FOR EMPLOYEE INFORMATION. PLEASE PRINT CLEARLY.

Member's Social Security No. or Personal ID No.	Last Name	First Name

Number and Street Address	Apt. No.	City & State	Zip Code

(Area Code) Business Phone	(Area Code) Home Phone

Department or Institution	Job Title	Date of Employment

PATIENT

First Name

☐ EMPLOYEE ☐ SPOUSE/DOMESTIC PARTNER

☐ CHILD AGE _____

Name of spouse/domestic partner's employer

_____

Name of spouse/domestic partner's insurance carrier

_____

_____ _____
Member's Signature Date

PROVIDER

THIS SECTION IS FOR PROVIDERS

SERVICES:
Please complete the requested and applicable information:

TYPE OF SERVICE	Please Check	CHARGES
Eye Examination	☐	$
Frames	☐	$
Single Vision Lenses	☐	$
Bifocal Lenses	☐	$
Trifocal Lenses	☐	$
Progressive Lenses	☐	$
Contact Lenses	☐	$
Cataract Single Vision Lenses over +8.00	☐	$
Cataract Bifocal Lenses over +8.00	☐	$
Cataract Contact Lenses	☐	$
Total		$

EXAMINER
Name _____
Address _____
Telephone No. _____
Date of Services _____

DISPENSER
Name _____
Address _____
Telephone No. _____
Date of Services _____

DC 37

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_____ _____ _____ _____
Claim No. Amount Claim Examiner Date

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