RETURN TO:
Administrative Services Only, Inc.
P.O. Box 9005
Department 136
Lynbrook, NY 11563
1-888-692-7671
www.asonet.com

NYSNA WELFARE PLAN

FOR NYC EMPLOYED REGISTERED PROFESSIONAL NURSES

OPTICAL FORM

Effective 4/1/09 Optical Benefits available for Full-Time Nurses and their dependents and Part-Time Nurses Member Only, once every 24 months.

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name	Birth date	Relationship to Member	Full Time College Student	School
		Spouse ☐ Child ☐	Yes ☐ No ☐	

MEMBER/EMPLOYEE INFORMATION

Member Name		Birth date		Social Security#
Street Address	City	State	Zip	Telephone# ( )
Member's School or Work Location		Work Telephone#		

SPOUSE INFORMATION

Spouse's Name (Print)	Birth date	Social Security #	Is spouse covered by another Benefits Plan? YES ☐ NO ☐
Name, Address, Telephone # of Spouses Employer			Name of Benefit Plan

ARE ANY OTHER OPTICAL BENEFITS AVAILABLE FOR THIS PATIENT? YES ☐ NO ☐ **IS THIS AN HMO PLAN?** YES ☐ NO ☐

PROVIDER INFORMATION (EXAMINER)

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#
Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

Certification of Examiner: I have examined the above named patient and have found the following vision defects:

Exam Fee($)

Signature of Examiner ______________________ Date ______________

PROVIDER INFORMATION (DISPENSER OF FRAMES AND LENSES)

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#
Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

WAS THE EXAMINATION REQUIRED BY: AN EMPLOYER AS A CONDITION OF EMPLOYMENT? Yes ☐ No ☐ BY A GOVERNMENT BODY? Yes ☐ No ☐

SERVICE	FEE($)	DATE	FOR OFFICE USE
FRAMES			
LENSES Single Vision			
Bifocal			
Trifocal			
Lenticular			
Contact Lenses			

You may check on eligibility for this benefit **24 hours a day, 7 days a week** by phone:
516-396-5561
800-537-1238 ex 5561
or
thru the internet:
www.asonet.com
Only claims with a service date on or after 4/1/09 will be honored. Benefits are limited to once every 24 months

Signature of Dispenser ______________________ **Date** ______________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, hospital, physician, or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct. **Authorization must be signed or payment will not be made.** *I understand that I am financially responsible for charges not payable by the Fund.*

Signed (Patient, or Parent if Minor) ______________________ **DATE** ______________

ASSIGNMENT OF BENEFITS: *I hereby authorize payment of the benefits (otherwise payable to me) directly to the above named physician. I understand I am financially responsible for charges not covered by this authorization.*

Signed (Member) ______________________ **DATE** ______________

BENEFITS CANNOT BE ASSIGNED TO NON-PARTICIPATING PROVIDERS.