

RETURN TO:
 SCCEA, Inc.
 1300 Veterans Memorial Highway
 Suite 130
 Hauppauge, NY 11788
 (1-631) 231-3983

SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION

WELFARE FUND

OPTICAL FORM

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name	Birth date	Relationship to Member Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Full Time College Student Yes <input type="checkbox"/> No <input type="checkbox"/>	School
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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 <input type="checkbox"/> NO <input type="checkbox"/>
Name, Address, Telephone # of Spouses Employer			Name of Benefit Plan
ARE ANY OTHER OPTICAL BENEFITS AVAILABLE FOR THIS PATIENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		IS THIS AN HMO PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>	

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 <input type="checkbox"/> No <input type="checkbox"/> Occupational Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Certification of Examiner: I have examined the above named patient and have found the following vision defects: Signature of Examiner _____ Date _____			Exam Fee(\$)

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 <input type="checkbox"/> No <input type="checkbox"/> Occupational Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>			
WAS THE EXAMINATION REQUIRED BY: AN EMPLOYER AS A CONDITION OF EMPLOYMENT? Yes <input type="checkbox"/> No <input type="checkbox"/> BY A GOVERNMENT BODY? Yes <input type="checkbox"/> No <input type="checkbox"/>			

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

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.