RETURN BY MAIL OR FAX TO:
SCCEA
1363-24 Veterans Memorial Highway
Hauppauge, NY 11788
Phone: (631) 231-3983
Fax: (631) 231-3986

SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION, INC.
WELFARE FUND
OPTICAL BENEFIT CLAIM FORM

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDANTS)

Patient Name	Patient Birth Date	Relationship to Member	Full-Time College Student? ☐ Yes ☐ No	School

MEMBER/EMPLOYEE INFORMATION

Member Name	Member Birth Date	Social Security #

Street Address	Telephone #

Member's Work Location	Work Telephone #

SPOUSE INFORMATION

Spouse's Name	Birth Date	SS#	Is Spouse Covered by Another Benefits Plan? ☐ Yes ☐ No

Name, Address, and Telephone # of Spouse's Employer	Name of Benefit Plan

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

PROVIDER INFORMATION (EXAMINER)

Provider's Name	License #	Telephone #	Taxpayer ID #

Street Address	City	State	ZIP Code

IS THIS CLAIM A 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 defects:

Exam Fee ($)

Signature of Examiner: _____ **Date:** _____

PROVIDER INFORMATION (DISPENSER OF FRAMES AND/OR LENSES)

Provider's Name	License #	Telephone #

Street Address	Taxpayer ID #

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

WAS THE EXAM 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 at:

(516) 396-5561

(800) 537-1238 x5561

or online at: www.ASONET.com

SIGNATURE OF DISPENSER _____ **DATE:** _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

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 or fax 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. I understand I am financially responsible for charges not payable by the Fund.

AUTHORIZATION MUST BE SIGNED OR PAYMENT WILL NOT BE MADE

FOR PAYMENT OF BENEFITS TO MEMBER

Signed: _____ **Date:** _____

PAYMENT OF BENEFITS TO PROVIDER: *I hereby authorize payment for 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: _____ **Date:** _____