KLDTA—Katonah Lewisboro District Teachers

C/O DANIEL H. COOK ASSOCIATES, INC.
1040 AVENUE OF THE AMERICAS, 24TH FLOOR
NEW Y ORK, NY 10018
(212) 505-5050

VISION CLAIM FORM

1. EMPLOYEE'S NAME		2. SOCIAL SECURITY NO.	GROUP # KLDTA
3. EMPLOYEE'S MAILING ADDRESS	(CITY)	(STATE or PROVINCE)	(ZIP CODE)
4. PATIENT NAME (IF A DEPENDENT)	5. RELATIONSHIP to EMPLOYEE	6. BIRTH DATE MO. DA. YR.	7. TEL.NO.
5. DOES PATIENT HAVE O\THER HEALTH COVERAGE? YES ☐ NO ☐ IF YES, PLEASE IDENTIFY			

SERVICE PROVIDED

Eye Examination, Including Refraction $ _____

	Sphere	Cylinder	Axis	Prism	Add For Reading
Right					
Left					

PRESCRIPTION

Did the patient have glasses prior to your examination? YES ☐ NO ☐

If Yes, is prescription for new lenses different from that of lenses being replaced? YES ☐ NO ☐

DATE OF THIS EXAMINATION _____

SIGNED _____ DEGREE _____ DATE _____

ADDRESS _____ PHONE _____

PROVIDER T.I.N.# _____

TO BE COMPLETED BY PROVIDER OF MATERIALS **Lenses For One Eye ☐** **Both Eyes ☐**

MATERIALS PROVIDED

Single Vision $_____ Bifocal $_____ Trifocal $ _____ Contact $_____ Sunglasses $ _____ Other $ _____

If contact lenses prescribed, give reason _____

Describe and indicate charges for special features such as hardening, tinting, plastic lenses, etc.— indicate seperately from lens charge.

_____

FRAMES

All Plastic, standard weight, style and hinges _____ $_____

Combination metal and plastic _____ $_____

All metal _____ $_____

Other materials, describe $

Are existing frames being used for the new lenses? YES ☐ NO ☐

If no, give reason

PROVIDER INFORMATION

Name: _____ **TAX ID #** _____

Street # / Name _____ **PHONE #** _____

City, State, Zip _____ **SIGNATURE:** _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

_____ _____
PATIENT SIGNATURE DATE

Authorization to pay benefits to physician: **I hereby authorize payment directly to the above physician for vision benefits otherwise payable to me for his/her services described on this form, but not to exceed the reasonable and customary fee for the service.**

_____ DATE _____
SIGNED (PATIENT, OR PARETNT IF MINOR)