United Food & Commercial Workers Unions
and Food Employers Benefit Fund

6425 Katella Avenue, Cypress, CA 90630-5246
P.O. Box 6010, Cypress, CA 90630-0010
877-284-2320 • medicalinfo@scufcwfunds.com

Vision Claim Form

How to Use this Form

If YOU PAID: Complete Sections 1, 2, 3, 5, 6 (if needed). Attach itemized bill & proof of payment.
If PROVIDER will be paid: Complete Sections 1, 2, 3, 4, 5, 6.

Submit completed form and required documents in one of three ways:

Upload to:	**Mail to:**	**Email to:**
Simply sign in to your secure Benefits+ My Portal at www.scufcwfunds.com/portal and select "Upload File"	UFCW Benefit Fund Office P.O. Box 6010 Cypress, CA 90630-0010	medicalinfo@scufcwfunds.com

1. Patient Information

Patient Name	Date of Birth (mm/dd/yyyy)	Relationship to Participant ☐ Self ☐ Child/Dependent ☐ Spouse/Domestic Partner	
Mailing Address *(if different from Participant)*	City	State	Zip Code

2. Other Coverage

Other Vision Coverage ☐ Yes ☐ No	Indicate other coverage

3. Participant Information

Participant Name	Date of Birth (mm/dd/yyyy)	Fund ID (accessible in the Benefits+ My Portal)

4. Assignment of Benefits (If paying provider directly)

I authorize payment directly to my provider for benefits otherwise payable to me. I understand I am responsible for charges not covered by the Fund.

Participant's Signature Date

5. Certification (Required to process your claim)

I certify the information above is true and authorize the release of necessary information to process this claim.

Participant's Signature Date

6. Attending Physician's/Optometrist's Statement

Diagnosis and complications, if any: _____

When did claimant first consult you for this condition? _____

_____

Payment for prescription lenses will be made only if no more than twelve months have elapsed between the date of the last vision examination and the fitting of the glasses or contact lenses, except when a lens change is required following eye surgery or other conditions.

Vision Care Services

Date of examination	Was corrective eyewear ordered? ☐ Yes ☐ No	Date ordered
Refraction? ☐ Yes ☐ No	Was corrective eyewear dispensed? ☐ Yes ☐ No	Glasses prescribed? ☐ Yes ☐ No

Changes and Services Rendered:

Examination Fee:		$ _____
Single Vision Lenses:	Number _____	$ _____
Bifocal Lenses:	Number _____	$ _____
Trifocal Lenses:	Number _____	$ _____
Other:	Number _____	$ _____
Frames:	Number _____	$ _____
Total Charges:		$ _____

Provider Information

Optometry Group Name (If applicable)			Tax ID Number
Physician's or Optometrist's Last Name	First Name	Mid.Initial	Phone Number
Street:	City	State	Zip Code

Provider's Certification

I hereby authorize the United Food & Commercial Workers Unions and Food Employers Benefit Fund to examine the patient's medical records upon presentation of authorization signed by the patient or qualified person.

_____

Attending Physician's Signature Date