Make sure you are Eligible. If you are not – no reimbursement shall be made	**PHILADELPHIA FEDERATION OF TEACHERS** **HEALTH AND WELFARE FUND** **1816 CHESTNUT STREET PHILADELPHIA, PA 19103** **BASIC VISION CARE PROGRAM**	**E ____ NE ____**

I. To be completed by eligible member of PFT Bargaining Unit

Name of employee of the PFT Bargaining Unit (please print)

Last ______________________ First ______________________ SSN or EMP ID No. ______________

Home Address of Employee (Include Apartment Number)

____

Number Street City State Zip Home Phone Work Location-Position

Name of Patient (Please Print)

_______________________________ ______________________ ______________________

Last, First Relationship to employee Age of patient if patient is other than employee or Spouse

☐ ____

Check here if spouse is a member of the PFT Bargaining Unit and list spouse's name and Social Security Number (for coordination)

II. Section to be completed by Ophthalmologist or Optometrist

1. Printed Name of Doctor ______________________________ Title______________
   Last, First
2. Date of Examination ____________ Were glasses or contact lenses prescribed? ☐ yes ☐ no
3. Was there a change in prescription that necessitated a change in the lenses? ☐ yes ☐ no
4. If there was a change please answer: (Not applicable for first pair of glasses under this program)
   a. Was there a change of at least plus or minus .50 diopters? ☐ yes ☐ no
   b. Was there a change in the axis of at least 20°? ☐ yes ☐ no
   c. Was there any other change that would require a change of lens? Describe ______________________
5. If Contact Lenses were prescribed, were they medically required? ☐ yes ☐ no If the answer is yes, have the Patient follow directions given in program description.
6. How much was the charge for the examination? $____________
7. Doctor's signature______________________________ I.R.S. Identification Number ______________

   Address______________________ City________________ State ____ Zip ________ Phone # ____________

III. Section to be completed by Optometrist or Optician

1. Printed Name ______________________________ Title ______________________
   Last, First
2. Date of completed glasses or contact lenses ______________________________
3. Type of lenses

   ☐ Single ☐ Bifocal ☐Trifocal ☐ Lenticular ☐ Contact (Check Instructions) ☐ Other ______________
4. How much was the charge per lens? $_____ x 2= $____________
5. How much was the charge for the frames? $________________
6. Signature ____________________ I.R.S. Identification Code ____________ or employer's ID No. .____________

   Address ______________________ City __________ State ______ Zip ________ Phone No. ____________

IV. To be completed by the member of the PFT Bargaining Unit

1. Remember to check information sheet for maximum allowances and regulations
2. When this form is completed, sign it below and send it to the Philadelphia Federation of Teachers, Health and Welfare Fund Vision Program, 1816 Chestnut Street, Philadelphia, PA 19103.
3. Is the patient eligible for payment for any of the above services or items from any other program including an HMO?

   ☐ yes ☐ no

   If yes, name HMO or other provider ______________________________________

   If yes, does HMO have a special list of providers? ☐ yes ☐ no

   Did you elect to use an HMO listed provider? ☐ yes ☐ no

   Did you or will you receive reimbursement from an HMO? ☐ yes ☐ no

   If yes, how much? ____________________ What for? ______________________________

Date of Prev. Exam	
Change in Rx? Yes ☐ No ☐	
Exam Chge. $______	**Exam Allow.** $______
Date of Prev. Lenses / /	
Lenses Chge. $______	**Lenses Allow.** $______
Date of Prev. Frames / /	
Frame Chge. $______	**Frame Allow.** $______
Total	
Chge. $______ –	**Allow.** $______ –
Completed by	
Check Sent Yes ☐ No ☐	
Check No.	

JF USW 10-286/AFL-CIO

*Signature ______________________________

***Required in order to be processed**