[redacted]

CENTRAL STATES SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND

MAIL TO:

Central States Southeast and Southwest Areas
Health and Welfare Fund
Claims Processing - - Vision
PO Box 5116 Des Plaines, IL 60017-5116
1-800-323-5000

FOR OFFICE USE ONLY - DO NOT WRITE ABOVE THIS LINE

MEMBER'S STATEMENT-PLEASE PRINT

Member's Soc. Security Number	Member's First Name	Middle Initial	Last Name	Member's Birth Date (Month / Day / Year)	Sex
					☐ M ☐ F

IF ADDRESS HAS CHANGED SINCE LAST CLAIM, PLACE "X" IN THIS BOX. ☐

Member's Street Address	Member's City & State	Zip Code

Local Union	Employer Name

Patient's First and Last Name	Relationship to Member	Patient's Birth Date (Month / Day / Year)
	☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Other (explain) _____	

PLEASE NOTE: PROVIDER OF SERVICE MUST COMPLETE BELOW SECTION: IF NOT, ATTACH RECEIPTS

TYPE OF SERVICE

Diagnosis _____

Exam Date _____

Charge $ _____ 810

Purchase Date _____

Lens Charge $ _____ /PAIR

Lens Type	Single Vision	Bi Focal	Tri Focal	Lenti Cular	Contact Lens
	☐	☐	☐	☐	☐
	821	822	823	824	825

Frame Charge $ _____ 830

PROVIDER OF SERVICE

Dr. _____

Address _____

City, State, Zip _____

Tax ID# _____

Dr/Opt _____

Address _____

City, State, Zip _____

Tax ID# _____

_____
Doctor's Signature

PLEASE NOTE: ALL BENEFITS TO BE PAID ARE SUBJECT TO THE 12 MONTH MAXIMUM IN YOUR VISION PLAN. EXTRA CHARGES FOR TINT, SCRATCH COATING, OVERSIZE LENSES, ETC., ARE NOT COVERED UNDER THE TERMS OF THE PLAN.

ASSIGNMENT OF BENEFITS: I hereby assign any benefit under the provision of the Plan to provider(s) listed above.

☐ EXAM

☐ LENS/FRAME

_____
SIGNATURE OF MEMBER DATE

DV6 4/2008

Print Form