

**COMPLETE AND RETURN TO:  
FITZHARRIS AND COMPANY, INC.  
PO BOX 9182  
FARMINGDALE, NY 11735**

**VISION CARE  
Statement of Claim**

TEL: (516) 777-2244  
(800 321-1336)

**PART 1 TO BE COMPLETED BY EMPLOYEE/MEMBER**

|  |  |   |  |   |  |  |  |                                     |                                    |          |                                  |                                       |  |
|--|--|---|--|---|--|--|--|-------------------------------------|------------------------------------|----------|----------------------------------|---------------------------------------|--|
| 1 PATIENT NAME   |  |   | 2 RELATIONSHIP TO MEMBER<br>SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OVER <input type="checkbox"/> |   |  |  | 3 SEX<br>M <input type="checkbox"/> F <input type="checkbox"/> |                                     | 4 PATIENT BIRTHDATE<br>MO DAY YEAR |          |                                  | 5 IF FULL TIME STUDENT<br>SCHOOL CITY |  |
| 6 MEMBER BIRTHDATE<br>MO DAY YEAR  |  | 7 MARITAL STATUS<br><input type="checkbox"/> MARRIED<br><input type="checkbox"/> DIVORCED |  | <input type="checkbox"/> SINGLE<br><input type="checkbox"/> WIDOWED |  | 8 SPOUSE'S NAME  |  | 9 SPOUSE'S BIRTHDATE<br>MO DAY YEAR |                                    |          | 10 SPOUSE'S SOC. SEC. NO.<br>/ / |                                       |  |
| 11 INSURED NAME<br>FIRST NAME MIDDLE LAST  |  |   |  |   |  | 12 MEMBER SOCIAL SECURITY NO.  |  |                                     | 13 GROUP NAME                      |          |                                  |                                       |  |
| 14 MAILING ADDRESS<br>CITY, STATE, ZIP   |  |   |  |   |  | 15 ARE OTHER FAMILY MEMBERS EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>NAME SOC. SEC. NO.<br>If Yes, Indicate |  |                                     |                                    |          |                                  |                                       |  |
| 17 IS PATIENT COVERED BY ANOTHER PLAN?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |   |  | PLAN NAME  |  | UNION LOCAL                         |                                    | GROUP NO |                                  | NAME AND ADDRESS OF CARRIER           |  |
|  |  |   |  |   |  | 16 NAME AND ADDRESS OF SPOUSE'S EMPLOYER IN ITEM 15  |  |                                     |                                    |          |                                  |                                       |  |

TO: All providers of medical services and supplies, employers, insurance institutions and other organizations. I authorize release to Fitzharris & Co., my employer or other representative any information, including medical, employment and benefit information required for claim processing or plan administration. This authorization is valid for one year after the date signed. A copy of this authorization shall be as valid as the original. I understand I may request a copy of this authorization.

Benefits assigned to provider of services:  Yes  No

Any person who knowingly and with intent to defraud any fund or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Eligible member \_\_\_\_\_

Date \_\_\_\_\_

**PART 2 TO BE COMPLETED BY OPTOMETRIST OR OPHTHALMOLOGIST OR SUPPLIER**

|   |  |                 |   |  |  |                 |     |
|---|--|-----------------|---|--|--|-----------------|-----|
| 1 OPTOMETRIST/OPHTHALMOLOGIST OR SUPPLIER   |  |                 | 7 IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES IF YES, ENTER BRIEF DESCRIPTION AND DATES |  |  |                 |     |
| 2 MAILING ADDRESS   |  |                 | 8 IS TREATMENT RESULT OF AUTO ACCIDENT?   |  |  |                 |     |
| 3 CITY, STATE, ZIP  |  |                 | 9 OTHER ACCIDENT?   |  |  |                 |     |
| 4 SOC SEC. OR T.I.N.  |  | 5 LICENSE NO.   | 6 PHONE NO.   |  | 10 ARE ANY SERVICES COVERED BY ANOTHER PLAN? |                 |     |
| 11. DESCRIPTION OF SERVICES   |  | DATE OF SERVICE | FEE   | 11. DESCRIPTION OF SERVICES  |  | DATE OF SERVICE | FEE |
| A EXAMINATION   |  |                 |   | F LENSES ONLY 1) SINGLE VISION   |  |                 |     |
| B SINGLE VISION WITH FRAME  |  |                 |   | 2) BIFOCAL   |  |                 |     |
| C BIFOCAL WITH FRAME  |  |                 |   | G CONTACT LENSES   |  |                 |     |
| D FRAME ONLY  |  |                 |   | H OTHER  |  |                 |     |
| E TINT  |  |                 |   | I TOTAL CHARGES  |  |                 |     |
| 12 PLEASE COMPLETE THE FOLLOWING  |  |                 |   | C INDICATE DIAGNOSIS OR NATURE OF DISEASE OR VISION DISORDER _____   |  |                 |     |
| A WERE LENSES PRESCRIBED AS A RESULT OF EYE SURGERY? YES _____ NO _____                   |  |                 |   | D IF TINTED GLASSES WERE FURNISHED, WERE THEY SPECIFICALLY PRESCRIBED FOR MEDICAL REASONS?<br>YES _____ NO _____ |  |                 |     |
| IF "YES" PLEASE SPECIFY PROCEDURE _____   |  |                 |   | E PLEASE SIGN BELOW  |  |                 |     |
| B WHAT IS PATIENT'S PRESENT DEGREE OF VISUAL ACUITY?<br>CORRECTED _____ UNCORRECTED _____ |  |                 |   | SIGNATURE  |  | DATE            |     |

**PART 3 EMPLOYER/PLAN ADMINISTRATOR**

|   |  |                                  |                                |            |                                |           |  |          |  |
|---|--|----------------------------------|--------------------------------|------------|--------------------------------|-----------|--|----------|--|
| MEMBER  |  | MEMBER ID NUMBER (if applicable) |                                | GROUP NAME |                                | POLICY NO |  | DIVISION |  |
| DATE BENEFITS BECAME EFFECTIVE<br>EMP Mo Day Year DEP Mo Day Year |  |                                  | DATE TERMINATED<br>Mo Day Year |            | SIGNATURE OF AUTHORIZED PERSON |           |  | DATE     |  |