Central Laborers' Welfare Funds
P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • Fax 217/243-8619
http://www.central-laborers.com

VISION CLAIM FORM

Insured to Complete Information Below

PATIENT NAME: ______________________ PATIENT DATE OF BIRTH: ______________

POLICY HOLDER NAME: ______________________ POLICY ID #: ______________

PATIENT ADDRESS: ______________________ CITY: ______________

______________________ STATE: ________ ZIP: ________

PATIENT PHONE NUMBER: ______________________________

IS THE PATIENT COVERED BY ANY OTHER VISION INSURANCE: ☐ YES ☐ NO

IF THE PATIENT IS COVERED BY OTHER VISION INSURANCE, PLEASE INCLUDE THE OTHER INSURANCE EXPLANATION OF BENEFITS WITH THIS CLAIM FORM.

PROVIDER to Complete Information Below

NAME OF VISION SERVICE PROVIDER: ______________________________
PROVIDER TAX ID/NPI#: ______________________________
VISION PROVIDER ADDRESS: ______________________________

VISION PROVIDER CITY: ______________ STATE: ________ ZIP: ________

EXAMINATION DATE: ______________ DATE GLASSES WERE PURCHASED: ______________

WAS THIS A ROUTINE VISION EXAMINATION: ☐ YES ☐ NO
IF NO, PLEASE EXPLAIN WHY EXAMINATION WAS PERFORMED:
EXAMINATION DIAGNOSIS CODE(S): ______________________________
PHYSICIAN'S SIGNATURE: ______________ DATE: ______________

SERVICE INFORMATION

SERVICE	PROCEDURE CODE	QTY	AMOUNT
UNLESS OTHERWISE SPECIFIED, PAYMENT WILL BE SENT TO THE POLICYHOLDER			
EYE EXAMINATION	☐ 92012 ☐ 92014		
FRAMES	☐ V2020 ☐ V2025		
SINGLE VISION LENSES	☐ ☐		
BIFOCAL LENSES	☐ ☐		
TRIFOCAL LENSES	☐ ☐		
CONTACT LENSES	☐ ☐		
OTHER EXAMINATIONS	☐ 92015 ☐ ☐		
OTHER BILLED SERVICES			

I CERTIFY THAT THE INFORMATION ON THIS FORM IS CORRECT AND AUTHORIZE THE PROVIDER TO RELEASE APPROPRIATE INFORMATION NECESSARY TO PROCESS THIS CLAIM ACCORDING TO PLAN PROVISIONS. ADDITIONALLY, I HAVE READ AND UNDERSTAND THE CLAIM PROCESSING STATEMENT AND FRAUD STATEMENT ON THE BACK OF THIS FORM.
PATIENT (OR PARENT'S SIGNATURE IF UNDER 18 YEARS): ______________________ DATE: ______________

FRAUD STATEMENT

Any person who knowingly and with intent to defraud Central Laborers' Welfare Fund submits a claim form or application/statement for benefits containing any false, incomplete or misleading information may be subject to civil or criminal penalties. Central Laborers' Welfare Fund will enforce the refund policy (see your Summary Plan Description for details) on any claims that were paid based on misinformation, lack of information or false information submitted by a patient, his/her parent or legal guardian, if under the age of 18 years, an authorized representative of the patient or his/her parent or legal guardian, if under the age of 18 years, or any provider of service.

HOW YOUR CLAIM IS PROCESSED

ONCE A CLAIM FORM IS RECEIVED, Central Laborers' Welfare Fund WILL REVIEW THE DOCUMENTATION SUBMITTED AND DETERMINE IF THERE IS SUFFICIENT INFORMATION TO PROCESS THE CLAIM.

IF ADDITIONAL INFORMATION IS NEEDED, YOU AND YOUR PROVIDER WILL BE NOTIFIED OF WHAT IS NECESSARY TO COMPLETE A DETERMINATION FOR BENEFITS.

IF A CLAIM IS COMPLETE, OR AFTER ADDITIONAL INFORMATION IS RECEIVED, Central Laborers' Welfare Fund WILL DETERMINE IF THE PROVIDER OF SERVICE PARTICIPATES IN YOUR POLICY'S NETWORK (FOR EXAMPLE – IF YOU ARE ENROLLED UNDER THE BLUE CROSS/BLUE SHIELD NETWORK, THE FUND OFFICE WILL DETERMINE IF THE INDIVIDUAL OR FACILITY WHO PROVIDED YOU SERVICES IS A PARTICIPATING PROVIDER IN THE BLUE CROSS/BLUE SHIELD NETWORK.)

IF THE PROVIDER OF SERVICE DOES PARTICIPATE IN YOUR POLICY'S NETWORK, THE CLAIM WILL BE FORWARDED TO THE NETWORK REPRESENTATIVES FOR DISCOUNTS TO BE APPLIED.

ONCE A CLAIM HAS BEEN PRICED AND IS RETURNED TO Central Laborers' Welfare Fund, THE EXPENSES WILL BE PROCESSED FOR PAYMENT.

REIMBURSEMENT ON ANY EXPENSES FOR VISION SERVICES THAT ARE PAYABLE TO YOU WILL BE MAILED IN A CHECK TO THE ADDRESS ON FILE.

REIMBURSEMENT ON ANY EXPENSES FOR VISION SERVICES THAT ARE PAYABLE TO YOUR PROVIDER WILL BE MAILED IN A CHECK TO THE ADDRESS LISTED ON THIS CLAIM FORM.

PLEASE NOTE, PROCESSING OF A PAYMENT TO YOU OR YOUR PROVIDER MAY TAKE UP TO 4 WEEKS, ASSUMING ALL INFORMATION IS PROVIDED TO Central Laborers' Welfare Fund IN A TIMELY FASHION.

IF YOU HAVE QUESTIONS REGARDING THE STATUS OF YOUR VISION CLAIM, PLEASE CONTACT Central Laborers' Welfare Fund AT 1-800-252-6571.