



# Direct Optical Reimbursement Form

PSC CUNY Welfare Fund

61 Broadway, 15th Floor

New York, NY 10006

Phone: 212-354-5230 Fax: 212-354-5363

FILE WITHIN 90 DAYS OF SERVICE. *ALLOW 6 TO 8 WEEKS FOR REIMBURSEMENT.*

<b>Member</b>	
Last Name _____	First Name _____
Street Address _____	
City _____	State _____ Zip Code _____
Social Security Number _____	Job Title _____
Employer (College) _____	
Member Status:	<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA <input type="checkbox"/> Survivor <input type="checkbox"/> Leave of Absence

<b>Patient</b>	
Relationship to Member	<input type="checkbox"/> Self <input type="checkbox"/> Spouse / Domestic Partner <input type="checkbox"/> Dependent Child
<i>Complete the following only if the Patient is <u>not</u> the Member :</i>	
Name of Patient _____	
Other Optical Coverage:	Name of Employer or Union _____ Contact _____

<b>To Be Completed by Provider</b>	
Name _____	License No. _____ Lic. Type _____
Street Address _____	
City _____	State _____ Zip Code _____
<u>Type of Service</u>	<u>Charges</u>
Single Vision Lenses	<input type="checkbox"/> _____
Bifocal Lenses	<input type="checkbox"/> _____
Trifocal Lenses	<input type="checkbox"/> _____
Prescr. Sunglasses	<input type="checkbox"/> _____
Contact Lenses	<input type="checkbox"/> _____
	Exam Only <input type="checkbox"/> _____
	Frames Only <input type="checkbox"/> _____
	Other <input type="checkbox"/> _____
	Other <input type="checkbox"/> _____
	Total Charges \$ _____

Signature of Member _____	Date _____
Signature of Provider _____	Date of Service _____ Date _____

OFFICE USE ONLY : Check # _____	Check Date _____	Amt. _____	Approved _____
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