COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY

RETURN COMPLETED FORM:
Attention: Claims Dept.
PO Box 9255
Uniondale, NY 11553-9255

PART A – TO BE COMPLETED BY MEMBER – PLEASE PRINT — STATEMENT OF VISION CARE EXAMINATION AND MATERIAL

1. Patient's Name (Last, First, Middle)	2. Patient's Relationship to Employee: ☐ Self ☐ Spouse ☐ Child	3. Patient Date of Birth	4. Patient's Sex ☐ M ☐ F

5. Member's Name (Last, First, Middle)	6. Member's Social Security Number	7. Member Date of Birth

8. Member's Address City, State, Zip	9. Member's Status ☐ Active ☐ Part Time ☐ Retiree

10. If Claim is due to accident, indicate date, time, place and how accident occurred	11. Did accident occur at work? ☐ Yes ☐ No

12. To all physicians and other health professionals, and all hospital and other health care institutions. You are authorized to provide Healthplex, Inc. and any independent claim administrators and consulting health professionals acting on Healthplex's behalf information concerning health care advice, treatment or supplies provided to the the patient. This information will be used for the purpose of evaluating and administering claims for benefits. Healthplex may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the Policy contract. This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Date _____ Patient's or Authorized Person's Signature _____

13. I hereby authorize payment directly to the doctor and/or dispenser of the vision care benefits otherwise payable to me.

Member's Signature _____ Date _____

PART B – TO BE COMPLETED BY DOCTOR

1. Please check one: ☐ Non-Participating ☐ Participating 2. Doctor's Name (Last, First, Middle)	3. Enter the taypayer I.D. # to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number. _____	PROFESSIONAL SERVICES	AMOUNT
4. Doctor's Address City, State, Zip		Examiniation Charge	
5. Phone Number / 6. Title ☐ MD ☐ DO ☐ OD / 7. Examination Date / 8. Has cataract surgery been performed? ☐ Yes ☐ No		Sales Tax	
9. Can visual acuity be restored to 20/70 or better eye with conventional eyeglasses? ☐ Yes ☐ No	10. If not, was it corrected to better than 20/70 with the use of contact lens? ☐ Yes ☐ No	Total	
11. Type of Examination ☐ 9501 Optometrist without tests ☐ 9502 Optometrist with tests ☐ 9503 Ophthalmologist ☐ 9506 Refraction	Was exam required as a condition of of employment? ☐ Yes ☐ No	Amount Paid by Patient	
12. Additional Comments			
13. I hereby certify that I have performed the services as indicated hereon. Doctor's Signature _____ Date _____			

PART C – TO BE COMPLETED BY DISPENSER

In lieu of dispenser completing this section a laboratory bill can be attached. Dispenser must sign this form, enter amount paid by patient. _____

1. Please check one: ☐ Non-Participating ☐ Participating 2. Dispenser's Name	3. Enter the taxpayer I.D. # to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number. _____	PROFESSIONAL SERVICES	AMOUNT
4. Dispenser's Address	5. Phone Number	Lens Charge	
		Frame Charge	

6. Dispenser's Title ☐ Opthalmologist ☐ Optician ☐ Optometrist	7. Purchase Date of Lenses	8. Purchase Date of Frames	OPTIONS			
				Opt	Lens	
					Frm	
				Disp. Fee	Lens	
					Frm	

9. Type of lenses/frames dispensed ☐ 9511 Single ☐ 9512 Bifocal ☐ 9513 Trifocal ☐ 9514 Lenticular ☐ 9516 Progressive ☐ 9517 Transitional ☐ 9521 Contacts ☐ 9541 Frames ☐ 9561 Sunglass – Lenses ☐ 9562 Sunglass - Frames

10. If contact lenses, please complete. Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses? ☐ Yes ☐ No	11. If not, was it corrected to better than 20/70 with the use of contact lenses? ☐ Yes ☐ No	Sales Tax (if any)	
11. I hereby certify that I have performed the services as indicated hereon. Dispenser's Signature _____ Date_____		Total	
		Amount Paid by Patient	

COURT OFFICERS BENEVOLENT ASSOCIATION
OF NASSAU COUNTY

VISION CARE BENEFITS REQUEST FORM

HOW TO REQUEST BENEFITS

INSTRUCTIONS FOR EMPLOYEE:

1. COMPLETE THE "PATIENT INFORMATION" (PART A - ITEMS 1 THROUGH 14) ON THE REVERSE SIDE OF THIS FORM. PLEASE PRINT OR TYPE.

2. If you wish for your benefits to be paid directly to your Doctor, Optometrist or provider of materials, sign item 13. A separate form should be submitted for each family member. Please be sure you have provided the Member's Social Security Number.

3. **SEND THE COMPLETED "BENEFIT REQUEST FORM" DIRECTLY TO HEALTHPLEX.**

INSTRUCTIONS FOR DOCTOR/OPTOMETRIST:

1. PLEASE COMPLETE PART B OF THE REVERSE SIDE OF THIS FORM (EXAMINING DOCTOR OR OPTOMETRIST INFORMATION) AND SIGN YOUR NAME. PLEASE RETURN THE COMPLETED FORM TO YOUR PATIENT.

INSTRUCTIONS FOR DISPENSER OF MATERIALS:

1. PLEASE COMPLETE PART C OF THE REVERSE SIDE OF THIS FORM (SUPPLIER INFORMATION) AND RETURN THE COMPLETED FORM TO THE PATIENT.

"Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits fraudulent insurance act, which is a crime."

MAIL COMPLETED FORM TO:

HEALTHPLEX
THE DENTAL BENEFIT EXPERTS℠

Attention: Claims Dept.
PO Box 9255
Uniondale, NY 11553-9255
Providers Call – (888) 468-2183 Press Option 1 for IVR or Option 3
Members Call – (888) 468-5178 Press Option 1