



# VOLUNTARY HOSPITALS HOUSE STAFF BENEFITS PLAN

520 EIGHTH AVENUE, SUITE 1200, NEW YORK, NY 10018-4181  
Phone: (212) 356-8180 Fax: (212) 356-8181 benefits@cirseiu.org http://www.cirseiu.org/benefits

## OPTICAL EXPENSE CLAIM FORM

Eligibility: VHHSBP\* employees including eligible dependents are entitled to this benefit once each benefit year. The benefit year runs from July 1st through June 30th.

Covered Services:

- § Eye exam by an optometrist or ophthalmologist
- § Replacement of broken frames
- § Prescription lenses
- § Prescription sunglasses
- § Prescription contact lenses (may include fitting)

Maximum reimbursement allowed: You and your eligible dependents are entitled to a maximum of \$100 optical benefit per plan year.

Claim Submission Rules:

- § Entire claim form must be completed in full by participant, patient or parent, if minor.
- § A separate claim form must be submitted per patient.
- § You must attach an original bill from your provider. The bill must state the provider's name and address, patient's name, the service which was performed, date of service, and amount of purchase. If glasses or contact lenses are purchased, the bill must have the word "prescription" on it or enclose a copy of the prescription. No photocopies, charge receipts or cancelled checks can be considered for reimbursement.
- § All claims must be submitted to our office at the above-mentioned address within one year of the date of service. Claims submitted after one year will be denied.

Please complete the following:

Participant's Name: \_\_\_\_\_  
(Last Name) (First Name)

Social Security No.: \_\_\_\_\_ Hospital where employed: \_\_\_\_\_

Home Address: \_\_\_\_\_

(City) (State) (Zip code)

Contact phone number: \_\_\_\_\_ Type (home, mobile, etc.) \_\_\_\_\_

E-mail address: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
(Last Name) (First Name)

Relationship to participant: \_\_\_\_\_

Number of Explanations of Benefits (EOB's) attached: \_\_\_\_\_

Patient's Signature or parent, if minor: \_\_\_\_\_ Date: \_\_\_\_\_

\* VHHSBP includes Bronx-Lebanon Medical Center, Brookdale Hospital Medical Center, Brooklyn Hospital Center, Flushing Hospital Medical Center, Interfaith Medical Center, Jamaica Hospital, Jersey City Medical Center, Kingsbrook Jewish Medical Center, Maimonides Medical Center, New York Methodist Hospital, North General Hospital, Our Lady of Mercy Medical Center, St. John's Episcopal Hospital, St. Luke's-Roosevelt Medical Center, Saint Vincent's Catholic Medical Center-BQ, Wyckoff Heights Medical Center.