UFT OUT-OF-NETWORK OPTICAL CLAIM FORM

*Complete and return this claim form to GVS. An itemized paid receipt and a copy of the eye exam prescription **must** accompany the claim form. To receive coverage for both the eye exam and glasses, you are required to obtain both services at the same location.*

Part 1: Patient Information

UFT Member's Name: _____

Enter one of the following: UFT Member ID, Welfare Fund Alternate ID or last 5 of SSN: _____

Street Address: _____

City & State: _____ Zip Code: _____

Telephone: _____ (Home) _____ (Work) _____

Member Email Address: _____

Patient's Name: _____ ☐ Male ☐Female

Patient's DOB: _____ Date of Service: _____

Relationship to Patient: ☐Member ☐Spouse/Domestic Partner ☐Child

☐Special Coordination of Benefits (SCOB)

If checked, please be sure to include spouse/domestic partner's first and last name and one of the following: UFT Member ID, Welfare Fund Alternate ID or last 5 digits of SSN

Full Name: _____ ID or SSN: _____

Part 2: Authorized Signatures *(18 years or older)*

Patient's Signature: _____

Member's Signature: _____

Part 3: Member Declaration

To the best of my knowledge, the above information is true and correct and I or my dependent have received the service indicated above. In the event I receive an overpayment of benefits on my behalf or on behalf of my dependent, I am obligated to refund said overpayment to the fund immediately.

Member's Signature: _____Date: _____

Instructions:

1. Confirm information in Part 1 is correct. To make changes, please call **212.729.5395.**
2. Sign Part 2 where indicated.
3. Sign and Date Part 3
   Return this form along with a paid itemized receipt for optical services and an eye exam prescription to General Vision Services, Att: OON-Dept, 520 Eighth Avenue, Suite 900, New York, NY 10018
4. General Vision Services will issue reimbursement checks to the members name and address on record.
5. Reimbursement is $175.00 or the actual charge, whichever is lower. Reimbursement will be $20.00 for an eye exam only, when no other services are rendered.

PLEASE NOTE: Claims must be submitted within 90 days of the Date of Service

You can now submit your out-of-network claim online

1. Logon to gvsuft.com
2. Fill out the required fields
3. Upload Supporting Document(s) - a copy of paid, itemized receipt and eye exam prescription are required

GVS GENERAL® VISION SERVICES
generalvision.com

OON Department
520 8th Avenue, 9th Floor
New York, NY 10018