



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.

Member	
Last Name _____	First Name _____
Street Address _____	
City _____	State _____ Zip Code _____
Is this a new address? (Please circle) YES NO	
Social Security Number _____	Job Title _____
Employer (College) _____	
Member Status: <input type="checkbox"/> Active <input type="checkbox"/> Adjunct <input type="checkbox"/> Retired <input type="checkbox"/> COBRA <input type="checkbox"/> Survivor <input type="checkbox"/> Leave of Absence	

Patient	
Relationship to Member	<input type="checkbox"/> Self <input type="checkbox"/> Spouse / Domestic Partner <input type="checkbox"/> Dependent Child date of birth _____
<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 _____

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

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

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