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: ☐ Active ☐ Retired ☐ COBRA ☐ Survivor ☐ Leave of Absence

Patient

Relationship to Member ☐ Self ☐ Spouse / Domestic Partner ☐ Dependent Child child's date of birth _____

Complete the following only if the Patient is <u>not</u> the Member :

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	Charges		Charges
Single Vision Lenses	☐	Exam Only	☐
Bifocal Lenses	☐	Frames Only	☐
Trifocal Lenses	☐	Other	☐
Prescr.Sunglasses	☐	Other	☐
Contact Lenses	☐		

Total Charges $ _____

Signature of Member _____ **Date** _____

Signature of Provider _____ **Date of Service** _____ **Date** _____

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