

CONED RETIREES

Vision Care Claim Form

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	M	ANAG	EMEN	T RI	ETIF	REE				
								Member's Name:		
VΩ	UCHER	NIIMRE	R:				5 Digit CE Employee ID (or Insured's SSN):			
•	OOHLIK	HOMBL		(DOC	CTOR	FILL IN)	Member's Date of Birth:		
CALL THE C.P.S. ELIGIBILITY SYSTEM								Patient's Name:		
C	ALL IF		S. ELIG 212) 67!		'	SYSIE	Patient's Date of Birth:			
or logon to: www.CPSOPTICAL.com								Relationship: Member Spouse Dependent		
	O BE	COMP	LETE) B	Y O	PTICA	L PRC	VIDER:		
			ER (PLE							
		ADDRES			- 1					
CI	ΓΥ, STA	IE, ZIP						PHONE NO.		
	RX REQUIRED (NEW RX)						СНЕСК	DATHENT CHIPCH A DCEC	FIXED	
	SPH	CYL	AXIS	AD		PRISM	BOX	PATIENT SURCHARGES	SURCHARGE	
R							╟╠	Polycarbonate Single Vision: Max. Surcharge = \$25		
L							╟╚	Polycarbonate Multifocal: Max. Surcharge = \$30		
	If RX changed after 12 months, provider						┧╬	Plastic Photosensitive SV: Max. Surcharge = \$60		
	must add the previous RX below. SPH CYL AXIS ADD PRISM						╢╬	Plastic Photosensitive Multifocal: Max. Surcharge = \$65		
R	5111	012	11110	1111		11101/1	╢╩	Standard AR Coating: Max. Surcharge = \$35		
L				\vdash			╢╩	Polarized Single Vision: Max. Surcharge = \$70		
UNION						INION	┧╚	Polarized Multifocal: Max. Surcharge = \$75		
SERVICES RECEIVED ALLOWANCE								Varilux Comfort 2 Progressive: Max. Surcharge = \$90		
Examination								Hi-Index Single Vision 1.60 index: Max. Surcharge = \$50		
Single Vision								Hi-Index Multifocal 1.60 index: Max. Surcharge = \$55		
Bifocal								Other (List Service)		
Trifocal							L	TOTAL SURCHARGES TO THE PATIENT:		
Progressive										
Frame							If patient is under age of 18, parent please sign.			
Contact Lenses							.,			
TOTAL CHARGES TO THE FUND							X_ Sigr	nature of Patient or Parent Date of Se	rvice	
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