CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL & FAMILY COURTS IN THE CITY OF NEW YORK WELFARE TRUST FUND

OPTICAL CLAIM FORM

NON-PPO CLAIMS MAIL TO: ADMINISTRATIVE SERVICES ONLY, INC PO BOX 9005, DEPT 150, LYNBROOK, NY 11563
PPO CLAIMS MAIL TO: COMPREHENSIVE PROFESSIONAL SYSTEMS (CPS) 11 HANOVER SQ., 8TH FLR, NY, NY 10005

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name	Birth date	Relationship to Member	Full Time College Student	School
		Spouse ☐ Domestic Partner ☐ Child ☐	Yes ☐ No ☐	

MEMBER/EMPLOYEE INFORMATION

Member Name		Birth date	Social Security# XX X-XX-☐☐☐☐
Street Address	City	State Zip	Telephone# ( )
Member Status ACTIVE ☐ RETIREE ☐	Court	Location	Work Telephone# ( )

SPOUSE INFORMATION

Spouse's Name (Print)	Birth date	Social Security #	Is spouse covered by another Benefits Plan? YES ☐ NO ☐
Name, Address, Telephone # of Spouses Employer			Name of Benefit Plan

ARE ANY OTHER OPTICAL BENEFITS AVAILABLE FOR THIS PATIENT? YES ☐ NO ☐ **IS THIS AN HMO PLAN?** YES ☐ NO ☐

PROVIDER INFORMATION (EXAMINER) PARTICIPATING Yes ☐ No ☐

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#
Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF:
Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

Certification of Examiner: I have examined the above named patient and have found the following vision defects:

Exam Fee($)

Signature of Examiner _____ Date _____

PROVIDER INFORMATION (DISPENSER OF FRAMES AND LENSES) PARTICIPATING Yes ☐ No ☐

Provider's Name (Print)	License #	Telephone #	Taxpayer ID#
Street Address	City	State	Zip Code

IS THIS CLAIM THE RESULT OF: Accident or Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

WAS THE EXAMINATION REQUIRED BY: AN EMPLOYER AS A CONDITION OF EMPLOYMENT? Yes ☐ No ☐ BY A GOVERNMENT BODY? Yes ☐ No ☐

SERVICE	FEE($)	DATE	FOR OFFICE USE
FRAMES			
LENSES Single Vision			
Bifocal			
Trifocal			
Lenticular			
Contact Lenses			

You may check on eligibility for this benefit **24 hours a day, 7 days a week** by phone:
1-800-537-1238 ext 5561
or thru the internet:
www.asonet.com
Please visit www.cpsoptical.com for a current listing of participating providers

Signature of Dispenser _____ **Date** _____

AUTHORIZATION TO RELEASE INFORMATION Authorization must be signed or payment will not be made.
I hereby authorize any insurance company, prepayment organization, hospital, physician, or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct. I understand that I am financially responsible for charges not payable by the Fund.

Signed (Patient, or Parent if Minor) _____ **DATE** _____

ASSIGNMENT OF BENEFITS: *I hereby authorize payment of the benefits (otherwise payable to me) directly to the above named physician. I understand I am financially responsible for charges not covered by this authorization.*

Signed (Member) _____ **DATE** _____

BENEFITS CANNOT BE ASSIGNED TO NON-PARTICIPATING PROVIDERS.