COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY HEALTH AND WELFARE FUND

STATEMENT OF VISION CARE EXAMINATION AND MATERIAL

Return this form to:
COBANC Health & Welfare Fund
1 Old Country Rd., Ste 282
Carle Place, NY 11514-1845
Email: info@cobanc.org

PART A – TO BE COMPLETED BY MEMBER – PLEASE PRINT

1. Patient's Name (Last, First, Middle)	2. Patient's Relationship to Member: ☐ Self ☐ Spouse ☐ Child	3. Patient Date of Birth	4. Patient's Sex
5. Member's Name (Last, First, Middle)		6. Member Date of Birth	
7. Member's Address	City / State / Zip	8. Member's Status ☐ Active ☐ Part-Time ☐ Retiree	
9. If claim is due to an accident, indicate date, time, place and how accident occurred		10. Did accident occur at work? ☐ Yes ☐ No	

11. To all physicians and other health professionals, and all hospitals and other health care institutions: You are authorized to provide COBANC Health & Welfare Fund and any independent claim administrators and consulting health professionals acting on COBANC's behalf information concerning health care advice, treatment or supplies provided to the patient. This information will be used for the purpose of evaluating and administering claims for benefits. COBANC may provide the member named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy contract. This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted.

Date _____ **Patient's or Authorized Person's Signature** _____

12. I hereby authorize payment directly to the doctor and/or dispenser of the vision care benefits otherwise payable to me.

Member's Signature _____ **Date** _____

PART B – TO BE COMPLETED BY DOCTOR

1. Please check one: ☐ Non-Participating ☐ Participating 2. Doctor's Name (Last, First, Middle)	3. Enter the taxpayer I.D. # to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number. _____	PROFESSIONAL SERVICES	AMOUNT
4. Doctor's Address / City / State / Zip		Examination Charge	
5. Phone Number / 6. Title ☐ MD ☐ DO ☐ OD / 7. Examination Date / 8. Has cataract surgery been performed? ☐ Yes ☐ No		Sales Tax	
9. Can visual acuity be restored to 20/70 or better in better eye with conventional eyeglasses? ☐ Yes ☐ No	10. If not, was it corrected to better than 20/70 with the use of contact lenses? ☐ Yes ☐ No	Total	
11. Type of Examination ☐ 9501 Optometrist without tests ☐ 9502 Optometrist with tests ☐ 9503 Ophthalmologist ☐ 9506 Refraction	Was exam required as a condition of employment? ☐ Yes ☐ No	Amount Paid by Patient	
12. Additional Comments			

13. I hereby certify that I have performed the services as indicated hereon.

Doctor's Signature _____ **Date** _____

PART C – TO BE COMPLETED BY DISPENSER

In lieu of the dispenser completing this section, a laboratory bill can be attached.
The dispenser must sign this form and enter the amount paid by the patient. _____

1. Please check one: ☐ Non-Participating ☐ Participating 2. Dispenser's Name	3. Enter the taxpayer I.D. # to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number. _____	PROFESSIONAL SERVICES	AMOUNT
4. Dispenser's Address / 5. Phone Number		Lens Charge	
		Frame Charge	
6. Dispenser's Title ☐ Ophthalmologist ☐ Optician ☐ Optometrist / 7. Purchase Date of Lenses / 8. Purchase Date of Frames	OPTIONS	Opt: Lens / Frm	
9. Type of lenses/frames dispensed ☐ 9511 Single ☐ 9512 Bifocal ☐ 9513 Trifocal ☐ 9514 Lenticular ☐ 9516 Progressive ☐ 9517 Transitional ☐ 9521 Contacts ☐ 9541 Frames ☐ 9561 Sunglass – Lenses ☐ 9562 Sunglass – Frames		Disp. Fee: Lens / Frm	
10. If contact lenses, please complete. Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses? ☐ Yes ☐ No	11. If not, was it corrected to better than 20/70 with the use of contact lenses? ☐ Yes ☐ No	Sales Tax (if any)	
12. I hereby certify that I have performed the services as indicated hereon. **Dispenser's Signature** _____ **Date** _____		Total	
		Amount Paid by Patient	

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HOW TO REQUEST BENEFITS

INSTRUCTIONS FOR MEMBER:

1. Complete **Part A** (Items 1 through 12) on the reverse side of this form. Please print or type.
2. If you wish for your benefits to be paid directly to your doctor, optometrist or provider of materials, sign item 12. A separate form should be submitted for each family member.
3. **Send this completed form to COBANC Health & Welfare Fund by mail or email.**

INSTRUCTIONS FOR DOCTOR/OPTOMETRIST:

1. Please complete Part B of the reverse side of this form (examining doctor or optometrist information) and sign your name. Please return the completed form to your patient.

INSTRUCTIONS FOR DISPENSER OF MATERIALS:

1. Please complete Part C of the reverse side of this form (supplier information) and return the completed form to the patient.

"Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."

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