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** _____

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

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* _____