

**BETHPAGE CONGRESS OF TEACHERS  
BENEFIT TRUST FUND**

c/o Vision Screening  
1919 Middle Country Road  
Centereach, New York 11720

**TO BE COMPLETED BY ELIGIBLE MEMBER**

Name and Home Address (Please Print)				Date of Birth	
Last	First	Middle Initial	Social Security Number	<input type="checkbox"/> Male	<input type="checkbox"/> Female
				Mo.	Day Yr.

Number Street	City	State	Zip Code	Marital Status:	
				<input type="checkbox"/> Single	<input type="checkbox"/> Divorced
				<input type="checkbox"/> Married	<input type="checkbox"/> Widowed

Please indicate Spouses name	Social Security Number	Spouses Date of Birth	Is your Spouse employer?
		Mo. Day Yr.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please indicate Spouses name and complete address

Is patient also covered by any Group Health Plan or HMO provided by:

- a. Another employer, union, trade association, school or arrangement of coverage for individuals in a Group?  Yes  No  
 b. Medicare/Medicaid, or any other federal, state, or government agency?  Yes  No

If either is answered "Yes", please indicate in "Remarks" the policy number, insurance company and the name and address of the employer, union, trade association, school, governmental agency, or any other arrangement for Group coverage.

Was illness or injury due, in any way, to the patient's occupation?  Yes  No If "Yes", please describe in "Remarks."

Is claim due to an accident  Yes  No If "Yes", give date and explain in "Remarks" where and how injury occurred.

- a. If auto accident, circle whether patient was the owner, driver, passenger or pedestrian and whether vehicle was private passenger, taxi, bus, truck, or other. Also, furnish name of automobile owner, insurance company and policy number, and state in which accident occurred.  
 b. For all accidents: Does the patient expect to receive, or has the patient received, payment for these expenses from another source as the result of a lawsuit or settlement?  Yes  No If "Yes" please provide details in "Remarks".

Remarks:

Dependent Information / Complete only if Patient is a Dependent

Name of Dependent	<input type="checkbox"/> Relationship	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	Date of Birth	Marital Status
	<input type="checkbox"/> Other (specify):			Mo. Day Yr.	<input type="checkbox"/> Single <input type="checkbox"/> Divorced
					<input type="checkbox"/> Married <input type="checkbox"/> Widowed

If claim is for dependent child 19 or older: Name and complete address of school or employer and Dependents Social Security Number

Is child enrolled as full-time student?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is that child employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Be sure to complete for each claim Nature of illness	Number of Bills Attached	Covers Period	Total Charges
		From To	
		Mo. Day Yr. Mo. Day Yr.	

Authorization to release information - I hereby authorize any Provider, Insurer or other Organization to release any information regarding the history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

**X** \_\_\_\_\_  
SIGNED (PATIENT OR PARENT IF MINOR)      DATE

**ALL CLAIM CHECKS WILL BE DISBURSED TO MEMBERS ONLY**

CERTIFICATION - I certify that the foregoing information is true and correct.

**X** \_\_\_\_\_  
(MEMBER'S SIGNATURE)      DATE

**"NOTICE" to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or penalties can result from such acts."**

**HOW TO PRESENT A CLAIM**

(Please read carefully)

- Both sides of this must be completed - this side by the physician or supplier, the reverse side by the employee or member. A separate form is required each time a claim is submitted and for each member submitting a claim. To avoid delay, answer all questions, sign and date the Certification of Statements and the Patient's Authorization sections on the back of this form.
- If the physician or supplier does not complete the section below, please attach itemized bills showing the following:  

Name, address and Tax ID Number of physician or provider of service	Type of service(s) ( <b>Be certain</b> your physician indicates the appropriate code from the most recent edition of the Current Procedural Terminology (CPT) of HCFA Common Procedural Coding System (HCPCS))
Name of patient	Bills for drugs and medicines should show:
Date(s) service(s) rendered	Name and address of pharmacy
Charge(s) made	Name of person for whom the medicine was prescribed
Nature of illness or injury ( <b>Be certain</b> your physician indicates the appropriate diagnosis code(s) from the current revision of the International Classification of Diseases, Clinical Modification (ICD-CM))	Date(s) of purchase(s)
	Prescription number(s) and nature of medication(s)
- Please check all bills for accuracy. Do not present cancelled checks or cash register receipts as they do not contain the information needed to process a claim. Please follow the instructions in No. 2 above.**
- If you wish to retain copies of your bills, they should be obtained before your claim is submitted.
- If you or your dependent have received consideration of these expenses by another group plan, please attach a copy of your statements of payment or rejection from that plan.
- If you or your dependent are eligible for Medicare, please attach a copy of your statements of payment or rejection for these expenses received from Medicare Part A and Part B.
- Send the completed form, with bills attached to **Bethpage Congress of Teachers Benefit Fund, c/o Vision Screening Inc. 1919 Middle Country Road, Centereach, NY 11720.**

**TO BE COMPLETED BY PHYSICIAN OR SUPPLIER**

Name of Patient  
Last

First

Middle Initial

Name of Employer or Member  
Last

First

Middle Initial

DIAGNOSIS:

Date(s) of Service	Description of supplies or, if needed additional medical service information (Itemize all items - example... Exam, Frame, Lenses, Tint, Contact Lenses)	Charges

Physician's or Suppliers Name, Address, Zip Code & Telephone No.

Balance Due

Federal Tax Reporting No.  SSN

(IRS requirement)

EIN/TIN

|||

Signature of Physician or Supplier

Total Charge

Signed

Amount Paid

Date