Update 6/30/21

HASTINGS TEACHERS' ASSOCIATION BENEFIT FUND

Statement of Claim for: *Prescription* Optical Expense Reimbursement

Claim Year: September 1 to August 31

MAIL TO:
Administrative Services Only, Inc.
PO Box 9005, Dept. 29-M
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238
Or
UPLOAD *ALL* paperwork to ASONET.com

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	MALE ☐ FEMALE ☐		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO. ███-██-____		DAYTIME TELEPHONE NUMBER: EVENING TELEPHONE NUMBER:		

PATIENT INFORMATION (REQUIRED ON ALL CLAIMS)

Patient' Name	**Birth Date** ____/___/____	Relationship to Member ☐Self ☐Spouse ☐Domestic Partner ☐ Child

Is Patient Covered by Another Plan ☐ Yes ☐ No If Yes, supply name, address and phone number of plan and attach a copy of the Explanation of Benefits from the other plan, if applicable

SERVICE PERFORMED: CHECK ONE OR MORE SPACES

☐ **LENSES** ☐ **FRAMES** ☐ **CONTACTS**

AMOUNT CLAIMED $________________

CLAIM YEAR: SEPTEMBER 1 TO AUGUST 31

FILING DEADLINE: ALL CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS AFTER SERVICES ARE RENDERED.

CLAIM YEAR MAXIMUM BENEFIT: YOU MAY CLAIM UP TO $450 FOR AN INDIVIDUAL, $600 FOR A FAMILY PER CLAIM YEAR (SEPTEMBER 1 TO AUGUST 31) TOTAL FOR **PRESCRIPTION** LENSES AND/OR FRAMES FOR YOURSELF, SPOUSE OR DEPENDENT.

HOW TO FILE A CLAIM: YOU MUST SUBMIT WITH THIS CLAIM FORM, **A COPY OF AN OPTOMETRIST or OPTHAMOLOGIST'S PRESCRIPTION**, AN ORIGINAL BILL, WHICH INCLUDES THE PATIENT'S NAME, DATE OF SERVICE, SERVICES RENDERED, AND THE CHARGES. PAYMENT WILL BE MADE DIRECTLY TO YOU, NOT THE PROVIDER OF SERVICES.

COVERED EXPENSES:	NON COVERED EXPENSES:
• PRESCRIPTION LENSES • FRAMES • COATINGS • CONTACTS	• OPTICAL EXAMS • SHIPPING • TAXES • LENSE SOLUTION • NON-PRESCRIPTION OPTICAL PURCHASES

MEMBER SIGNATURE-REIMBURSEMENTS ARE PAYABLE TO THE MEMBER ONLY.

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, 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. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WERE THE AMOUNT BILLED.

____ ____________________

SIGNATURE OF MEMBER **DATE**