UNITED PLANT AND PRODUCTION WORKERS LOCAL 175
WELFARE FUND

In Care of Dickinson Group
50 Charles Lindberg Blvd. Ste. 207, Uniondale, NY 11553
Telephone: 516-833-9300 Fax: 516-740-5309

PRESCRIPTION OR EYE CLAIM FORM

Member's Name ..... S.S. No. ☐☐☐ ☐☐ ☐☐☐☐
Address .....

If Dependent—Name and Relationship .....

EYE CARE PROGRAM TO BE COMPLETED BY OPTOMETRIST—OPTICIAN or OPHTHALMOLOGIST

To determine whether or not he or she needs corrective vision in the form of eye-glasses. Yes ☐ No ☐

Please check one. ** BILLS FOR EXAMINATION, EYE GLASSES AND/OR CONTACTS MUST ALL BE SUBMITTED AT THE SAME TIME, OR NO PAYMENT WILL BE MADE.**

Amount Charged:

Examination	$ .....
Single Vision Lenses	$..... With ☐ or Without Frames ☐
Bifocal Vision Lenses	$ ..... With ☐ or Without Frames ☐
Trifocal Vision Lenses	$ ..... With ☐ or Without Frames ☐
Contact Lenses	$ .....
Total Charges	$ .....

Amount Paid by Member $ .....

Date .....Signed .....

Address .....

Ophthalmologist ☐ Optician ☐ Optometrist ☐

PRESCRIPTION CLAIM

Diagnosis .....

Rx

PLEASE ATTACH PERSCRIPTION RECEIPT HERE

Pharmacy ..... Address .....

Signature of Pharmacist .....

This form must be **completed by member *or* pharmacy only.** Attach computerized receipt to this form.
All prescriptions must contain name, address, Social Security No. of member. Prescriptions for eligible dependents must also contain name and age of dependent and relationship to member. All prescriptions must be signed by person receiving medication.