



# VISION CARE BENEFIT CLAIM

## HAWAII LABORERS' HEALTH AND WELFARE TRUST FUND

PACIFIC ADMINISTRATORS, INC.

1440 Kapiolani Blvd., Suite 800 - Honolulu, Hawaii 96814

Phone: Oahu - (808) 441-8600; Neighbor Islands Dial Direct 1 (888) 520-8078; FAX - (808) 441-8750

**NOTE: Sign and return the completed form to the address above. Members are required to pay non-participating providers & suppliers in full. The Fund will then reimburse the member for the allowed amounts.**

<b>Part I - THIS SECTION IS FOR MEMBER INFORMATION ONLY - PLEASE PRINT</b>				<b>FOR OFFICE USE ONLY</b>	
LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NO.		
STREET ADDRESS or P.O. BOX				M.D.	_____
CITY				O.D.	_____
STATE				S V GLASSES	_____
ZIP CODE				BIFOCALS	_____
<b>PATIENT INFORMATION</b>				TRIFOCALS	_____
PATIENT NAME		RELATIONSHIP		CONTACTS	
				LENSES ONLY	
				FRAMES ONLY	
				TOTAL \$ _____	
				TOTAL PAID \$ _____	
				CHECK NO. _____	
I CERTIFY THAT THE INFORMATION CONTAINED HEREON IS TRUE AND CORRECT.				ELIGIBLE	DETERMINED BY:
MEMBER'S SIGNATURE _____		DATE SIGNED _____ / ____ / 20		INELIGIBLE	

<b>Part II - TO BE COMPLETED BY DOCTOR - ALSO COMPLETE PART III IF SUPPLIES DISPENSED BY YOU.</b>					
NAME OF PATIENT _____				DATE OF SERVICE	CHARGES Excluding Tax
LAST FIRST MIDDLE				/ / 20	
PROVIDER TAX NO. _____					
PLEASE PRINT		DOCTOR'S NAME		STREET ADDRESS	
		DEGREE			
		DOCTOR'S SIGNATURE		PHONE NO.	
		DATE SIGNED		CITY-STATE	

<b>Part III - TO BE COMPLETED BY SUPPLIER OF LENSES OR FRAMES.</b>					
NAME OF PATIENT _____				DATE OF SERVICE	CHARGES Excluding Tax
LAST FIRST MIDDLE				/ / 20	
<b>PLEASE INDICATE SERVICES RENDERED:</b>					
<input type="checkbox"/> LENSES AND FRAME		<input type="checkbox"/> TRIFOCAL LENSES		<input type="checkbox"/> LENSES ONLY	
<input type="checkbox"/> BIFOCAL LENSES		<input type="checkbox"/> CONTACTS		<input type="checkbox"/> FRAMES ONLY	
<input type="checkbox"/> OTHER _____				/ / 20	
PLEASE NOTE: COVERAGE DOES NOT INCLUDE SUNGLASSES OR REPLACEMENT FOR BROKEN GLASSES.					
PROVIDER TAX NO. _____					
PLEASE PRINT		NAME OF SUPPLIER		STREET ADDRESS	
		PHONE NO.			
		/ / 20		CITY-STATE	
		AUTHORIZED SIGNATURE OF SUPPLIER		ZIP CODE	

**CLAIMS MUST BE FILED WITHIN 90 DAYS FROM DATE SERVICE RENDERED**

**RETURN TO ADMINISTRATIVE OFFICE**