THE NATIONAL ASBESTOS WORKERS MEDICAL FUND
VISION CARE CLAIM FORM

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
800-386-3632, 410-872-9500

THE BENEFIT ALLOWANCE WILL BE PAID TO THE PARTICIPANT ONLY

Participant Name: _____ SS# or Alt ID: _____ Local: _____

Patient Name: _____ Patient Date of Birth: _____

Address: _____ Telephone #: _____

City, State: _____ Zip: _____

Was injury or illness (if any) due to your occupation? Yes No (circle one)

Do you have any other insurance coverage? Yes No (circle one)

If yes, name of insured: _____

Name of insurance company and policy number: _____

TO BE SIGNED BY PARTICIPANT:

The undersigned employee certifies that the above information is true and correct and the below services and materials were rendered and supplied as indicated. The undersigned also agrees to pay the doctor for the below services and materials. I hereby authorize the doctor to release the information requested on this form.

_____ _____
Participant Signature Date

TO BE COMPLETED BY DOCTOR

Examination Fee: _____ Ophthalmic Materials: _____

Lenses: _____ Date of Examination: _____

Patient Name: _____ Doctor's Name: _____
(Please Print)

Address of Doctor: _____

City, State, Zip: _____

_____ _____
Signature of Doctor Federal Tax ID #