Boilermakers National Health and Welfare Fund

MEMBER SUBMITTED VISION CLAIM FORM

FILING INSTRUCTIONS

1. Complete **all** items below **including** your signature and date. **All** of the information is essential for prompt and accurate processing of your claim(s).
2. Submit the claim and attach an **itemized** statement of services from the healthcare provider to Boilermakers National Health and Welfare Fund, P.O. Box 219118, Kansas City, MO 64121-9118. You may also email the documents to BNF-Claims@wilson-mcshane.com, or fax them to (816) 756-3659. Cancelled checks, cash register receipts or personal itemizations are not acceptable without the claim form and itemized statement.
3. The itemized statement **must** include name of patient, date(s) of service, type of services performed, diagnosis and charge(s).
4. You must use a separate claim form for each patient. All expenses for one patient can be submitted with one claim form.
5. If submitting a reimbursement claim from a Walmart Vision provider, you will need to request a "Lab Copy" statement, which will show patient information and itemized services / materials. Your vision claim will be denied if the Lab Copy is not received.

PATIENT INFORMATION

PATIENT'S NAME (first name, middle initial, last name)

PATIENT'S ADDRESS Street City State Zip Code

PATIENT'S DATE OF BIRTH (month, day, year)

PATIENT'S SEX:
- ☐ MALE
- ☐ FEMALE

PATIENT'S RELATIONSHIP TO THE POLICYHOLDER:
- ☐ SELF
- ☐ SPOUSE
- ☐ CHILD
- ☐ OTHER

POLICYHOLDER INFORMATION

NAME OF POLICYHOLDER (first name, middle initial, last name)

SOCIAL SECURITY NUMBER OF POLICYHOLDER

ADDRESS OF POLICYHOLDER (Street, City, State, Zip Code)

PHONE NUMBER
( )

NOTE: YOU SHOULD MAKE A COPY OF YOUR COMPLETED CLAIM FORM AND ITEMIZED BILLS FOR YOUR RECORDS.

If patient is covered by another insurance plan, please complete the following: OTHER INSURANCE COVERAGE INFORMATION
(*If you have an Explanation of Benefits, please attach*)

INSURED'S NAME ON OTHER INSURANCE CARD:	NAME OF OTHER INSURANCE COMPANY:
POLICY NUMBER:	ADDRESS OF OTHER INSURANCE COMPANY: (Street, City, State and Zip Code)
GROUP NUMBER:	OTHER INSURED'S EMPLOYER:

REMEMBER TO ATTACH AN ITEMIZED STATEMENT OF SERVICES PERFORMED

Signature _____ Date _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, Highmark may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient name.

The Fund may use and share participants' or beneficiaries' personal information within our organization, with business partners, and with other Boilermaker entities solely for the purpose of operating, administering, and delivering benefits, communications, and services.