Auxiant®
PO Box 75008
Cedar Rapids, IA 52407-5008
319-398-3283 or 800-475-2232

VISION CARE CLAIM FORM
IBEW Local 405

INSTRUCTIONS TO THE EMPLOYEE

(1) Complete form below.

(2) Attach itemized bills for expenses that you paid for. Benefits will be paid directly to you.

(3) Mail to the above address or fax to 319-398-3292

(4) Any questions please call extension 1299.

Employer Name IBEW LOCAL 405			Group Number 451
Employee name Last	First	MI	Member ID / SSN
Employee Address	City	State	Zip
Are you currently working? ☐ Yes ☐ No		If "No" give last date worked:	
Patient Name Last	First	Patient Date of Birth	Relationship
Is patient covered by any other medical benefit plan, group policy, prepayment plan, Medicare, or other Government plan? ☐ Yes ☐ No If Yes, provide type:			
Person carrying the other coverage:		Group (employer, association, etc.):	
Insurance Company or Plan:	Policy or Plan Number:	Address of other Insurance Company:	
Date of Service:		Total Charges:	

Services (Check all that apply):

Frames _____	Bifocal _____	Contact Lenses_____
Single Vision _____	Trifocal _____	Safety Glasses _____
Visual Training/Therapy _____	Low Vision _____	Other _____

(5) Return form and attachments to:

Auxiant
PO BOX 75008
Cedar Rapids, Iowa 52407-5008

(6) AUTHORIZATION TO RELEASE INFORMATION

I hereby certify that the foregoing statements, including any accompanying statements are true and complete to the best of my knowledge. I hereby authorize any physician, hospital, insurance company, organization or employer to release any information to including full copies of their records to Auxiant. For any medical treatment, services, or benefits rendered or payable to me (or my dependents). This authorization is valid from the date signed for the duration of the claim. I agree that a photocopy of this authorization shall be considered as valid as the original.

_____ _____
Signature of Employee Date

_____ _____
Signature of the Patient (if other than the Employee) Date