

Operating Engineers Local #49 Health and Welfare Fund

VISION AND HEARING REIMBURSEMENT CLAIM FORM FOR SENIOR GOLD MEDICARE RETIREES

Policy Number: **5WM00490**

Please check the appropriate box designating vision or hearing service reimbursement being requested:

Vision

Hearing

TO BE COMPLETED BY THE MEDICARE ELIGIBLE RETIREE/POLICY HOLDER

<p>1. Retiree/Policyholder Information</p> <p>Your Name: _____</p> <p>Social Security Number: _____</p> <p>Date of Birth: _____</p> <p>Address: _____</p> <p>_____</p>	<p>2. Patient Information (if same, simply print SAME)</p> <p>Name: _____</p> <p>Social Security Number: _____</p> <p>Date of Birth: _____</p> <p>Address: _____</p> <p>_____</p>
<p>3. Please Attach an Itemized Receipt Showing:</p> <ul style="list-style-type: none">• Provider's Name and Address• Patient's Name• Date, Place and Type of Service• Itemized Charges	<p>4. Please Include Verification of Blue Cross Blue Shield Discount with Itemized Receipt.</p>

I hereby certify that the statements provided above, as well as the supporting documentation are true and accurate and that I have received a discount from my coverage with Blue Cross Blue Shield prior to requesting this reimbursement through the Operating Engineers Local #49 Health & Welfare Fund.

<p>5. Participant Signature: _____ Phone Number: (____) _____ - _____</p> <p>Date of Signature: ____/____/_____</p>

Return completed form to:

Wilson-McShane Corporation
Attn: Claims Department
3001 Metro Drive – Suite 500
Bloomington, MN 55425

Phone: (952) 854-0795
Toll Free: (800) 535-6373
Fax: (952) 851-3521