Eye Care Reimbursement Claim Form

NYHTC & HA of NYC, Inc. Health Benefits Fund

The health plan reimburses eligible members and dependents up to **$200** annually for the purchase of eyewear (contact lenses, eyeglasses, reading glasses, sunglasses and upgrades) and eye exams conducted outside of the Funds' Health Centers.

To receive a reimbursement, you must:

- Complete this claim form
- Attach copies of your itemized receipt(s) and order detail
- Attach copies of your vision prescription (if applicable)
- Send the completed form and copies of your documents to:

  NYHTC - Eye Care

  PO Box 36-20953

  New York, NY 10129

FOR INTERNAL USE ONLY
Form Received By:
Date Received:

Keep original documents for your records. Please allow 4 to 6 weeks for processing

PATIENT/MEMBER INFORMATION (PLEASE PRINT)	
Patient Name:	Date of Birth:
Member's Identification Number (Last 4 digits of SSN):	
Member Name:	
Current Address:	
Total Amount Paid for Eye Care:	

Important Information:

1. All required information must be present when submitting a claim to avoid payment delay or the claim form being returned to you.
2. When visiting a provider, you are responsible for payment of services or materials at the time of service.
3. The Funds' will reimburse you and your eligible dependents up to $200 annually. Any unused balances will roll over up to a maximum of $400.
4. To allow for proper benefit allocation, please fill out a reimbursement claim form for each individual on your plan that requires reimbursement.
5. If the payment receipt is not in US Dollars, please identify the type of currency use for your purchase.
6. Reimbursements will be mailed to the current mailing address that the Funds' has on file for you. If you have recently moved or changed your address, please contact the Eligibility Department to update your information before submitting your claim.

Questions? Call us at 212-586-6400 or E-mail us at HBFServices@hotelfunds.org.