Fallsburg Teachers Association
Vision Reimbursement Form

The benefit is $300.00 every year for active employees and $200.00 every year for retired employees.

MEMBER INFORMATION:			
Member's Name:		Date of Birth:	
Address:			
City:		State:	Zip:
Member's ID or Social Security Number:			
PATIENT INFORMATION:			
Patient's Name:		Date of Birth:	
Relationship to Member:			
If the patient is a child (and over the age of 18):			
Is the child a full time student?	Y / N	Is the child physically impaired?	Y / N
Name of School:			
REIMBURSEMENT REQUEST INFORMATION:			
Date Services were received:			
Services Received: *(please circle any that apply and provide the amount paid for each)*			
Exam			$
Lenses: Single Vision Bifocal Trifocal Progressive Lenticular			$
Lens Options:			
Tint			$
Other* *(*includes scratch coatings, Anti-Reflective coating, etc.*)			$
Frame			$
Contact Lenses			$
Contact Fitting &/or Evaluation			$
PROVIDER INFORMATION:			
Provider/Optical Shop Name:		Phone Number:	
Address:			
City:		State:	Zip Code:

Coordination of Benefits Information:
If you are coordinating benefits with another insurance carrier, we need a complete copy of the Explanation of Benefits from your primary insurance carrier. The Explanation of Benefits must indicate the service(s) which were received, as well as the amount paid, denied, or applied to your deductible. This information can be obtained from the provider who performed your recent services.

Submit this form along with related receipts to:
MERIDIAN ADMINISTRATORS CORP.
1387 FAIRPORT RD BUILDING 1000 SUITE A-1
FAIRPORT NY 14450

800-666-6690