AN ITEMIZED PAID IN FULL RECEIPT MUST ACCOMPANY THIS FORM

BTF-SBF OPTICAL FORM

(PLEASE PRINT)

*IMPORTANT — SUBMIT CLAIMS FOR OUT-OF-POCKET EXPENSES

RETURN COMPLETED FORM WITH RECEIPTS TO:
BTF-SBF OPTICAL
271 PORTER AVENUE
BUFFALO, NEW YORK 14201

SECTION 1 — COMPLETED BY MEMBER AND SIGNATURE AT BOTTOM

1. Member's Name FIRST MIDDLE LAST

2. District ID # ___ ___ ___ ___ ___

3. Member's Mailing Address STREET | CITY | STATE | ZIP CODE | PAYROLL SCHOOL

4. Patient's Name | RELATIONSHIP TO MEMBER: Self | Spouse | Child | Other | SEX: M | F | PATIENT'S BIRTHDAY: Mo. | Day | Year

ELIGIBLE DEPENDENTS ARE COVERED UNTIL AGE 26.

SECTION 2 — COMPLETED BY EXAMINER

5. _____ Signature of Examiner

If Doctor Please Check ☐

6. Date of Exam: Mo. | Day | Year

7. Charge for Exam

8. Type of Exam

PREVIOUSLY USED BTF/SBF OPTICAL PLAN? ☐ YES ☐ NO

SECTION 3 — COMPLETED BY DISPENSER

9. Lenses Dispensed

	Charge for 1st Pair	Charge for 2nd Pair
☐ Single Vision		
☐ Bifocals		
☐ Trifocals ☐ Plastic ☐ Glass		
☐ Invisible Type _____		
☐ Hi-Lite / Hi-Index Single Vision		
(circle one) /Polycarbonate		
☐ 1 Pair Contacts RIGHT & LEFT		
☐ Left Contact Only		
☐ Right Contact Only		
☐ UV 400		
☐ Anti-reflective coating		
☐ Blue Light		
☐ Polarized		
☐ Transition		
☐ Edging		
☐ Prism		
☐ Other _____ (explain)		

10. Charge for Frames

1st Pair _____

2nd Pair _____

Date Frames Ordered _____

ACTUAL AMOUNT PAID MUST CORRESPOND WITH ITEMIZED RECEIPT AFTER PRIMARY OR DISCOUNTS

CALL (716) 881-5462 TO CHECK YOUR ELIGIBILITY
BTFNY.ORG FOR CLAIM FORMS, INFO, FEE REIMBURSEMENT

11. Date Lenses Ordered _____

12. X _____ Signature of Dispenser

13. Name and Address of Firm

Under penalty of loss of all supplemental benefits, the above information is accurate to the best of my knowledge.

X Signature of Member _____

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