UNITED WORKERS HEALTH FUND

50 CHARLES LINDBERGH BLVD. SUITE 207
UNIONDALE, NY 11553
516-833-9300

MEGA BUS OPTICAL VOUCHER

Date: _____

Member's Name: _____

Patient's Name: _____

Patient's Date of Birth: _____

Relationship to Member:

☐ **Member** ☐ **Spouse** ☐ **Daughter** ☐ **Son**

Eligible for: **EXAM** ☐ **Yes** ☐ **No**
GLASSES ☐ **Yes** ☐ **No**

Please include the original receipt and attach to the insurance claim form

TO BE COMPLETED BY OPTICAL PROVIDER:		
_____ **Optical Provider (Please Print)**		
Mailing Address		
City, State, Zip		
Social Security No. or T.I.N.	**License No.**	**Phone No.**

DESCRIPTION OF SERVICES RECEIVED	**DATE OF SERVICE**	**FEE**
Examination		
Single Vision		
Bifocal		
Frame		
Contact Lenses		
Other		
Total Charges		

I Have Received The Services Listed Above:

_____ _____

Patient's Signature **Date**