GVS | GENERAL® VISION SERVICES

CLAIMS DEPARTMENT
520 8th Ave, 9th Floor
New York, NY 10018
855.653.0584

TRANSPORT WORKERS UNION AFL-CIO LOCAL 100

TWU LOCAL 100 VISION OUT OF NETWORK CLAIM FORM

Member Information

Today's Date _____ Date of Service _____

Member's Name _____ BSC # _____

Member's Address _____

City _____ State _____ Zip Code _____

Member Phone _____ DOB _____

Patient Information

Patient Name _____ DOB _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

GENDER ❍ Male ❍ Female

RELATIONSHIP TO MEMBER ❍ Self ❍ Spouse / Domestic Partner ❍ Dependent

Provider Information

Name of Business _____ Phone _____

Address _____

City _____ State _____ Zip Code _____

Store's NPI _____ Doctor's NPI _____

Instructions for Reimbursement

Please return this form with original itemized receipt. All receipts must be submitted together at the same time even if services and materials were purchased on different dates. GVS will issue reimbursement checks to LOCAL 100 MEMBERS ONLY. No reimbursements will be issued for members who utilize in-network providers.

ALL OUT OF NETWORK CLAIMS MUST BE SUBMITTED WITHIN 6 MONTHS FROM THE DATE OF SERVICE.

Mail this form to General Vision Services with original itemized receipt for optical services to:

General Vision Services
Attn: Local 100-OON Claims
520 Eighth Avenue, Suite 900
New York, NY 10018

Member Signature _____ Date _____

GVS OFFICE USE ONLY

Date Request Received _____ Authorization Number _____

Check _____ Date Check Issued _____ Date Check Mailed _____