Law Enforcement Health Benefits Inc.

PO Box 21139 Philadelphia, PA 19114 215-364-3529
http://www.lehb.org

L.E.H.B. VISION FUND CLAIM FORM

Payroll Number or SS#_____ Member Name _____

Address: _____ City:_____ State:_____ Zip Code: _____

Patient's Name: _____ Patient's Date of birth: _____

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***Date of Service** _____ **DESCRIPTION OF SERVICES**

Office use Only	**Procedure**	**Charges**
VOT 01	Exam	$
VFR 01	Frame	$
VOS 01	Single Vision Lens	$
VBI 01	Standard Bifocal	$
VPL 01	Progressive Lens **Submit Lab slip**	$
VTR 01	Trifocal	$
VOC 01	Contacts	$
VPC 01	Polycarbonates	$
Transition Lens	**Not covered**	
	Total Charges	$

Frame Mfg: _____

Frame Name: _____

Wholesale Cost Frames: $_____

Spectacle or Contact Lens RX

PROVIDER INFORMATION

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

SS# TIN# _____ Telephone Number: _____

_____
I authorize payment directly to the Provider.
L.E.H.B. Member Signature

_____
I certify that I have provided the services and material indicated.
Provider's Signature

Rev. 2/10