

Law Enforcement Health Benefits Inc.

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

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

Payroll Number or SS# _____ Member Name _____

Address: _____ City: _____ State: _____ ZipCode: _____

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

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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