Law Enforcement Health Benefits Inc.

PO Box 21139Philadelphia, PA 19114 215-364-3529
https://www.lehb.org Fax 215-364-6556

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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***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