For Office Use Only: Vendor# _____

$_____

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CITY OF JERSEY CITY
OPTICAL CLAIM FORM

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Please Provide All Information Below:

Employee's Name: _____Social Security # _____

Date of Hire: _____

Patient's Name: _____ Patient's D.O.B:_____

Relationship to Employee: _____

Home Mailing Address: _____

Dept/Div: _____/_____ Phone Ext. _____

Please check one:

Union: 68 ____ 245 ____ 246 ____ 1064 ____ ANPH ____ JCSA ____

POBA ____ PSOA ____ STGA ____ MGT ____

Service Date _____ Total Fee _____

A COPY OF A PAID RECEIPT OF SERVICE MUST BE ATTACHED TO THIS FORM IN ORDER TO PROCESS YOUR CLAIM.

COMPLETED CLAIM FORMS SHOULD BE SENT TO THE OFFICE OF HEALTH BENEFITS, ROOM 107, CITY HALL. FORMS WILL BE RETURNED FOR MISSING INFORMATION.

ATTN: ALL MEMBERS OF LOCALS 245, 246, JCSA:
CLAIM FORMS MUST BE SUBMITTED WITHIN 90 DAYS OF THE SERVICE DATE

REIMBURSEMENT CHECKS ARE GENERATED BY TREASURY AND SENT TO DEPARTMENTS.