# ***LASIK Reimbursement Claim Form***

# ***Out of Network Claims***

Member Name: _____

BCBS ID or SS#: _____

Patient Name: _____ Patient Date of Birth: _____

Date of Service: _____

Description of Service: _____

Provider Name: _____

Provider Tax ID: _____

Total Amount of Claim: _____

- You ***MUST*** submit the 1) LASIK Reimbursement Claim Form and 2) An Itemized Invoice indicating the Patient's Name, Date of Service, Type of Service, and Total Charges to:

***Plumbers' Welfare Fund, Local 130 U.A.***
***1340 W. Washington Blvd, Ste. Ste. 300***
***Chicago, IL 60607***
***Ph. 312-226-4200***

Signature: _____ Date: _____