Operating Engineers Local #49 Health and Welfare Fund

VISION AND HEARING REIMBURSEMENT CLAIM FORM FOR MEDICARE RETIREES

Policy Number: **5WM00490**

Please check the appropriate box designating vision or hearing service reimbursement being requested:

☐ Vision ☐ Hearing

TO BE COMPLETED BY THE MEDICARE ELIGIBLE RETIREE/POLICY HOLDER

1. Retiree/Policyholder Information	2. Patient Information (if same, simply print SAME)
Your Name: ______ Social Security Number: ______ Date of Birth: ______ Address: ______ ______	Name: ______ Social Security Number: ______ Date of Birth: ______ Address: ______ ______
3. Please Attach an Itemized Receipt Showing: • Provider's Name and Address • Patient's Name • Date, Place and Type of Service • Itemized Charges	

I hereby certify that the statements provided above, as well as the supporting documentation are true and accurate.

5. Participant Signature: ______ Phone Number: (____) ____-____

Date of Signature: ____/____/________

Return completed form to:

Wilson-McShane Corporation
Attn: Claims Department
3001 Metro Drive – Suite 500
Bloomington, MN 55425

Phone: (952) 854-0795
Toll Free: (800) 535-6373
Fax: (952) 851-3521