BTF-SBF OPTICAL FORM

(PLEASE PRINT)

***IMPORTANT — A PAID RECEIPT MUST ACCOMPANY THIS FORM**

RETURN COMPLETED FORM WITH RECEIPTS TO:
BTF-SBF OPTICAL
271 PORTER AVENUE
BUFFALO, NEW YORK 14201

SECTION 1 — COMPLETED BY MEMBER AND SIGNATURE AT BOTTOM

1. Members Name FIRST MIDDLE LAST

2. Members Social Security No.

3. Members Mailing Address STREET | CITY | STATE | ZIP CODE | PAYROLL SCHOOL

4. Patient's Name | RELATIONSHIP TO MEMBER: Self | Spouse | Child | Other | SEX: M | F | PATIENT'S BIRTHDAY: Mo. | Day | Year

ELIGIBLE DEPENDENTS ARE COVERED UNTIL AGE 23.

SECTION 2 — COMPLETED BY EXAMINER

5. Patient's Name

6. Date of Exam Mo. | Day | Yr.

7. Charge for Exam

8. Type of Exam

9. _____ Signature of Examiner

If Doctor Please Check ☐

PREVIOUSLY USED BTF/SBF OPTICAL PLAN? ☐ YES ☐ NO

AN ITEMIZED PAID RECEIPT MUST ACCOMPANY THIS FORM

SECTION 3 — COMPLETED BY DISPENSER

10. Lenses Dispensed

	Charge for 1st Pair	Charge for 2nd Pair
☐ Single Vision		
☐ Flat-Top Bifocals		
☐ Trifocals ☐ Plastic ☐ Glass		
☐ Invisible Type _____		
☐ Executive Bifocal		
☐ Executive Trifocal		
☐ Hi-Lite / Hi-Index Single Vision (circle one)		
☐ 1 Pair Contacts		
☐ Left Contact Only		
☐ Right Contact Only		
☐ UV 400		
☐ Anti-reflective coating		
☐ Other _____ (explain)		

11. Date Lenses Ordered _____

12. Charge For Frames

1st Pair _____

2nd Pair _____

Date Frames Ordered _____

ITEMIZED RECEIPTS MUST CORRESPOND WITH SUBMITTED SERVICES

CALL (716) 881-5462 TO CHECK YOUR ELIGIBILITY

13. _____ Signature of Dispenser

14. Name and Address of Firm

Under penalty of loss of all supplemental benefits, the above information is accurate to the best of my knowledge.

Signature of Member _____