Administrative Services Only, Inc.
PO Box 9005, Dept 32.
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238
WWW.ASONET.COM

FARMINGDALE FEDERATION OF TEACHERS BENEFIT FUND
VISION CLAIM FORM

Please visit www.asonet.com and log into your member account for additional plan information, to print claim forms, track your claims and claim history, and to print your ID card, which will have your ASO member ID number.
NON-PPO CLAIMS MAIL TO: ADMINISTRATIVE SERVICES ONLY, INC. PO BOX 9005, LYNBROOK NY 11563
PPO CLAIMS- GVS PROVIDER MUST SUBMIT CLAIM TO GVS
NO ASSIGNMENT OF BENEFITS WHEN USING A NON-PPO PROVIDER

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	LAST 4 DIGITS OF SOC SEC # OR ASO MEMBER ID #		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
PATIENT NAME	BIRTH DATE	RELATIONSHIP ☐ MEMBER ☐ SPOUSE ☐ DEPENDENT		

- The Benefit Fund will reimburse each member and eligible dependents to a maximum of $250 per family in each calendar year for vision care services.
- Please attach a detailed paid receipt* from your vision care provider that includes the patient's name, services rendered, dates of services, and the total amount of charges.
  *NO CASH **REGISTER RECEIPTS, BILLING STATEMENTS, INTERNET, EMAIL OR CREDIT CARD CHARGE RECEIPTS** WILL BE ACCEPTED.
- This claim form, with attached paid receipt, should be submitted within 60 days of the date these services were rendered.

This is to inform you that it is your responsibility to inform BRI, Benefit Resource Inc., that an expense paid with your Beneversal Card has been reimbursed to you by the Farmingdale Federation of Teachers Benefit Fund. You will be required to reimburse the FLEX plan. **FAILURE TO REPAY THE PLAN COULD RESULT IN ADVERSE TAX CONSEQUENCES**

THE DEADLINE FOR SUBMISSION OF CLAIMS IS FEBRUARY 28 OF THE FOLLOWING YEAR.

PLEASE INDICATE DATE AND FEE FOR APPLICABLE SERVICES AND ATTACH REQUIRED DOCUMENTATION

SERVICE	DATE OF SERVICE	AMOUNT PAID
EXAMINATION		
EYE GLASSES		
CONTACTS		
OTHER		

You may check on eligibility for this benefit **24 hours a day, 7 days a week** by phone:
1-516-396-5561
or thru the internet:
www.asonet.com
Please visit www.generalvision.com
for a current listing of
participating providers

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

AUTHORIZATION TO RELEASE INFORMATION: MEMBER'S SIGNATURE IS REQUIRED ON ALL CLAIMS.
I hereby authorize any insurance company, prepayment organization, employer, healthcare provider, or the Board of Trustees to release all information with respect to me or any of my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

_____ _____
SIGNATURE OF MEMBER **DATE**