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 DOB: ___________________________

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
280 Grove Street - Jersey City, NJ 07302

Form will be returned for missing information.

ATTN: ALL MEMBER SOF LOCALS 245, 246, JCSA:

CLAIM FORMS MUST BE SUBMITTED WITHIN 90 DAYS OF THE SERVICE DATE.

REIMBURSEMENT CHECKS ARE GENERATED BY THE TREASURY AND SENT TO DEPARTMENTS.