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 D.O.B:__________

Relationship to Employee: ____

Home Mailing Address: ____

Dept/Div: ____________________/_____________________Phone Ext. ____________

Please check one:

Union: 68 ______ 245 _______ 246 _______ 641 ______ 1064 _______
JCSA ___ POBA ___ PSOA ____ STGA ____ MGT ____ RET______

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 DIVISION OF HEALTH BENEFITS, ROOM 106 OF CITY HALL. FORMS WILL BE RETURNED IF MISSING INFORMATION.

ATTN: ALL MEMBERS OF LOCALS 245, 246, 641, JCSA and MANAGEMENT EMPLOYEES:
CLAIM FORMS MUST BE SUBMITTED WITHIN 90 DAYS OF THE SERVICE DATE

REIMBURSEMENT CHECKS ARE GENERATED BY TREASURY AND SENT TO DEPARTMENTS AFTER SCHEDULED COUNCIL MEETINGS.