United Employees Benefit Trust
Non-Profit Provider of Employee Benefits Since 1965

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Fax: (253) 474-7180
E-mail: staff@unitedemployees.org

CLAIM FORM

MEMBER and PATIENT INFORMATION

Employee Name (First, Initial, Last) _____

Address _____ City, St, Zip _____

ID # _____ Group # _____

Patient Name (First, Initial, Last) _____

Relationship _____ Birthdate _____

PHYSICIAN OR SUPPLIER INFORMATION

DIAGNOSIS CODES: _____

DATE OF SERVICE	PLACE OF SERVICE	PROCEDURE	DESCRIPTION	DIAGNOSIS CODE	CHARGE	

PROVIDER'S NAME, ADDRESS and TELEPHONE NUMBER	PROVIDERS TAX ID NUMBER	TOTAL CHARGES	AMOUNT PAID	BALANCE DUE
		PHYSICIANS SIGNATURE		

VISION CLAIM (include receipt)

PROVIDER'S NAME, ADDRESS and TELEPHONE NUMBER					
PROVIDER'S TAX ID NUMBER	PHYSICIAN'S SIGNATURE			DATE	
PROFESSIONAL SERVICES	DATE	CHARGE	PROFESSIONAL SERVICES	DATE	CHARGE
VISION EXAM			CONTACTS		
SINGLE VISION LENSES			DISPOSABLE CONTACT LENS		
BIFOCAL LENSES			OTHER		
TRIFOCAL LENSES			OTHER		
FRAMES			SUBTOTAL		
			TAX		
			TOTAL		