AFL-CIO Health & Welfare Plan
SPECTERA VISION CARE
REIMBURSEMENT REQUEST FORM
FOR OUT OF NETWORK SERVICES ONLY

PART I - EMPLOYEE DATA

Employee's Name	Social Security #		
Address	**City**	**State**	**Zip Code**
Patient's Name	**Patient's Date of Birth**		
Relationship To Employee	**Date**		

PART II - REQUEST

To obtain reimbursement, complete this form and submit this with your itemized bill and paid receipts to :

SPECTERA CLAIMS DEPARTMENT
P.O. BOX 30978
SALT LAKE CITY, UT 84130
FAX: (248) 733-6060

I hereby request reimbursement for up to a maximum of $300 total for all services and materials below:

☐	Eye Exam	☐	Single Lenses
☐	Frames	☐	Bifocal Lenses
☐	Contact Lenses (Necessary)	☐	Trifocal Lenses
☐	Contact Lenses (Elective)	☐	Lenticular Lenses

Note: Receipts must be submitted <u>together</u> for services or materials purchased on different dates to receive reimbursement. Attach an itemized statement and paid receipt for your expenses.
A separate claim form must be submitted for each patient.
Contact lens reimbursements are in lieu of eyeglass lenses and frames.

Employee's Signature _____ Date _____

Spectera Customer Service: 1-800-638-3120