Active
Piggyback Vision Claim Form

PLEASE PRINT

CCPOA Member/Participant Name:		SSN:
Address:Address:		
City:	State:	ZIP:
Telephone:		
Patient Name:		Patient Birthdate:

YOUR EYE DOCTOR MUST COMPLETE AND SIGN THE FOLLOWING:

Name of Doctor/Optometrist:		
Address:		
City:	State:	ZIP:
Business Telephone:		

FIRST PAIR	Date of Service:	
VSP Exam Deductible: $	Material Deductible: $	Cost of Frame Less VSP Allowance: $
SECOND PAIR	Date of Service:	
VSP Exam Deductible: $	Material Deductible: $	Cost of Frame Less VSP Allowance: $
Signature of Doctor/Optometrist: **X**		Date:

MAIL TO:
CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

Please Attach One:
- ☐ Itemized Receipt
- ☐ Online Proof of Purchase
- ☐ VSP Savings Statement

We've Got You Covered.

1-800-In-Unit-6

1-800-468-6486