Retiree
Piggyback Vision Claim Form

PLEASE PRINT

CCPOA Member/Participant Name:		SSN:
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:		
Date of Exam:		Fee Charged: $
Were any Lenses purchased? (Circle One) ◯ YES ◯ NO	If Yes, Date:	Fee Charged: $
Type of Lens purchased: (Circle One) ◯ Single Vision ◯ Bifocals ◯ Trifocals ◯ Lenticular Lenses		
Were Frames purchased? (Circle One) ◯ YES ◯ NO	If Yes, Date:	Fee Charged: $
Signature of Doctor/Optometrist		Date:

MAIL TO: **CCPOA Benefit Trust Fund** 2515 Venture Oaks Way, Suite 200 Sacramento, CA 95833-4235	Please Attach an Itemized Receipt or VSP Savings Statement

We've Got You Covered.

1-800-In-Unit-6

1-800-468-6486