FRINGE BENEFIT SERVICES, INC.

PARTICIPATING VISION CARE PROVIDERS

Sharon Optical
1818 East State St #100
Hermitage, PA 16148
724-981-4441

Mastrian Optometric
490 N Kerrwood Dr #203
Hermitage, PA 16148
724-342-2733

Shawnee Optical
2926 East State St
Hermitage, PA 16148
724-346-2020

Keith Rowlands, OD
138 West Market St
Mercer, PA 16137
724-662-4313-1012

Art of Eyecare
2151 Shenango Valley Freeway Suite #3
Hermitage, PA 16148
724-346-5516

Joel P. Ways
89 East State St
Hermitage, PA 16148
724-347-5101

HERMITAGE SCHOOL DISTRICT

PARTICIPATING PROVIDER FEES		NON PARTICIPATING PROVIDER FEES	
EXAM	$ 40.00	EXAM	$ 32.00
SINGLE VISION	$ 39.00	SINGLE VISION	$ 30.00
BIFOCALS	$ 65.00	BIFOCALS	$ 40.00
TRIFOCALS	$ 80.00	TRIFOCALS	$ 50.00
FRAMES	$ 60.00	FRAMES	$ 25.00
CONTACTS WITH EXAM*	$ 100.00	CONTACTS WITH EXAM	$ 90.00 NO DISCOUNT

*PLAN PAYS 15% DISCOUNT ON CONTACTS BALANCE TO THE PROVIDER

PROVIDER GIVES 15% DISCOUNT ON BALANCE OF OTHER ELIGIBLE SERVICES

CODES FOR SERVICES WHERE FEES PAYABLE ARE ACCEPTED BY PARTICIPATING PROVIDERS AS PAYMENT IN FULL.

EXAM	UP TO	$40.00	20000
EXAM W/ REFRACTION	UP TO	$40.00	20100
SINGLE VISION	LESS THAN	$59.00	21100
BIFOCALS	LESS THAN	$80.00	21300
TRIFOCALS	LESS THAN	$90.00	21600
FRAMES	LESS THAN	$70.00	22200

IF THE PATIENT/EMPLOYEE ELECTS TO PURCHASE CONTACT LENSES, THIS BENEFIT IS IN LIEU OF ALL OTHER VISION BENEFITS FOR THE SAME LIMITATION PERIOD. THE BASIC ALLOWANCE SHALL BE APPLIED TOWARD THE COST OF THE CONTACT LENSES. ANY BALANCE SHALL BE SUBJECT TO THE APPLICABLE DISCOUNT AND REMAINS THE PATIENT'S RESPONSIBILITY TO THE PROVIDER.

ALL BENEFITS ARE PAYABLE ONCE IN EVERY 12 MONTH PERIOD.

BOTH GLASSES AND CONTACTS ARE NOT PAYABLE IN THE SAME 12 MONTH PERIOD.

ABSOLUTELY NO GRACE PERIOD!

Employee of:
Hermitage School District
411 North Hermitage Rd
Hermitage, PA 16148

Fringe Benefit Services Inc.

VISION CLAIM FORM

P.O. Box 670 • 79 Connelly Boulevard • Sharon, Pennsylvania 16146
Phone (724) 981-3300 or (800) 732-9281 • Fax (724) 981-4041

1. Patient Name first / m.i. / last	2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other _____	3. Sex m / f	4. Patient birthdate MM / DD / YYYY	5. If full time student school / city
6. Employee/Subscriber name and mailing address	7. Employee/Subscriber soc.sec. number	8. Employee/Subscriber birthdate MM / DD / YYYY	9. Employer(company) name & address	10. Group number 940701-01
11. Is patient covered by another plan of benefits? Vision _____ Medical _____	12a. Name and address of carrier(s)	12b. Group number(s)	13. Name & address of employer	
14a. Employee/Subscriber name (If different than patient's)	14b. Employee/Subscriber soc. sec. number	14c. Employee/Subscriber birthdate MM / DD / YYYY	15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other _____	

16. Provider	21. Is treatment result of occupational illness or injury?	No	Yes	If Yes, enter brief description and dates.
17. Mailing address	22. Is treatment result of auto accident?			
	23. Other accident?			
City, State, Zip	24. Are any services covered by another plan?			

18. Soc. Sec. Number or T.I.N. 19. License number 20. Phone number

25. Diagnosis or nature or illness or injury.

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26. Date of service or receipt	Place of service	Procedure code	Fully describe procedures, medical services or supplies furnished for each date given. (Explain unusual services or circumstances)	Charges

Has the patient's prescription changed by an axis of 20 degrees or a .50 diopter sphere or cylinder change and the new lenses improve the Plan Member's visual acuity by at least one line on the standard eye chart. ____ No ____ Yes

Total Charges

Amount Paid

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees that I have charged and intend to collect for those procedures.

Signed (Provider) Date

Signed (Insured person) Date