

Logging into the GVS Billing Website:

- 1. Go to www.gvsuft.com
- 2. Click on Plan Providers



Logging into the GVS Billing Website:

Enter your: Username
 Enter your: Password

3. Click **Log In**

GVS GENERAL VISION SERVICES			
User Login			
User ID		_	
Password		_	
© 2016 GVS		Change	Password LOG IN

1. Click: File Claims

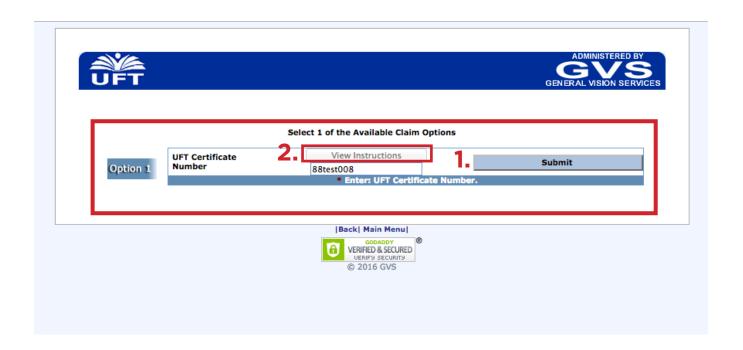
UFT	ADMINISTERED BY GENERAL VISION SERVICES
Please Select From the available options	
File Claims	
Report	
Claim Inquiry	
Lookup ICD-10 Codes	
Back Home GODADDY VEIRIED & SECURED URINITY SECURITY © 2016 GVS	

1. Select: Option 2

Enter: UFT Certificate Number

Click: Submit

2. View instructions for claim submission here.



Process Worksheet:

- 1. Click All the Services and Materials Dispensed
 - **a.** As you click the amount what the patient pays will automatically be added to the right hand column.
 - **b.** Fill in any information that is needed.
- Enter: Actual Amount to Charge to Fund and Actual Amount to Charge to Member at the bottom of the form.

GVS	GENERAL VISION SERVICES		
	UFT Worksheet View Instructions)	
Patier	nt First Name: PETER Patient Last Name: FOND	A	
	Patient DOB: 07/07/1977 Member Infomation		
			and Marrie Found
	First Name PETER Address 123 ANY S		ast Name FONDA
	City BRONX		e Select
	OILY BROTH	Phone	Zip 10403 3
Certificate #:		Q	8test019
	December 18, 2016	· ·	otest019
Certificate Valid from Monday, September 19, 2016 through Sund: Service Date:	ay, December 16, 2016		
UFT Provider #:		A. Carlotte and the second	
Part 3 - Service(s) Provided (Check all that apply) And Enter Retail C	harges - REQUIRED ENTRY		
		Retail Charges	Patient's Responsibility
✓ Single Vision Lens(es)	INCLUDED	49.00	0.00
Bifocal Lens(es)	INCLUDED		
□ Trifocal Lens(es) □ Progressives	INCLUDED Min. 10% DISCOUNT		
Eye Exam (Max. Retail Price \$20)	INCLUDED		
√ Frame	\$125 ALLOWANCE Additional up to \$100 Credit For Upgraded Frames	70.00	0.00
Contact Lenses (CTL)	\$125 ALLOWANCE		
S.C.O.B. (see back of certificate)			
LESS: WELFARE FUND BENEFIT			0.00
Surcharges (Patient's Responsibility)			
		Retail Charges	Patient's Responsibility
☐ Tinting < 40%	Max. \$15.00		
☐ Tinting > 40%	INCLUDED		
UV Block	Max. \$15.00		
Scratch Resistant Coating	Max. \$20.00		
Glare Free Coating	Max. \$30.00		
Eye Exam with Dilation	Max. \$30.00		
Polycarbonate	Max. \$35.00		
☐ Photochromic	Max. \$50.00		
UPGRADED SERVICES - MINIMUM 10% DISCOUNT ANY SERVICES NOT LISTED ABOVE RECEIVE A MINIMUM 10% DISCOUNT List any additional upgraded services below Do NOT bill for any services listed above.			
Upgraded Services Names		Retail Charges	Patient's Responsibility
fax. Amount to Charge to Fund:		119.00)
lax. Amount to Charge to Member:		0.00	
Actual Amount to Charge to Fund: Provider to bill fund usual and	customary or \$125. Whichever is less.(AMOUN	T MUST BE	- -1
ENTERED ON CERTIFICATE)	, ,	119.00	
actual Amount to Charge to Member: (AMOUNT MUST BE ENTERE		0.00	



Example #1:

	Retail Price
Designer Frames:	\$220
Progressive Lenses:	\$225
Total Retail Price:	\$445
10% Minumum Panelist Discount	(\$44.50)
Sub-Total:	\$400.50
Basic Frame Allowance (if upgraded)	(\$100.00)
Sub-Total:	\$300.50
Welfare Fund Benefit:	(\$125.00)
Member's Final Cost:	\$175.50

	GENERAL VISION SERVICES		
	UFT Worksheet View Instructions		
	Patient First Name: JANE Patient Last Name: FONI Patient DOB: 07/07/1987	DA	
	M	1ember Infomation	
	First Name JANE	Last Name FO	NDA
	Address 123 ANY STREET	Chata (a. I.	71-
	City BRONX Phone	State Select	‡ Zip 10465-3
ertificate #:		88te	st020
ertificate Valid from Monday, September 19, 2016 thro	ugh Sunday, December 18, 2016		
ervice Date:		10	13 / 2016
FT Provider #:			
art 3 - Service(s) Provided (Check all that apply) And En	ter Retail Charges - REQUIRED ENTRY		
		Retail Charges	Patient's Responsibility
Single Vision Lens(es) Bifocal Lens(es)	INCLUDED		
Trifocal Lens(es)	INCLUDED		
Progressives	Min. 10% DISCOUNT	225.00	202.50
Eye Exam (Max. Retail Price \$20)	INCLUDED		
	\$125 ALLOWANCE		
Frame	Additional up to \$100 Credit For Upgraded Frames	220.00	98.00
Contact Lenses (CTL)	\$125 ALLOWANCE		
S.C.O.B. (see back of certificate)			
SS: WELFARE FUND BENEFIT			-125.00
rcharges (Patient's Responsibility)		Retail Charges	Patient's Responsibility
Walter con		Ketali Charges	Patient 5 Responsibility
Tinting < 40%	Max. \$15.00		
Tinting > 40%	INCLUDED		
UV Block Scratch Resistant Coating	Max. \$15.00 Max. \$20.00		
Glare Free Coating	Max. \$30.00		
Eye Exam with Dilation	Max. \$30.00		
Polycarbonate	Max. \$35.00		
Photochromic	Max. \$50.00		
PGRADED SERVICES - MINIMUM 10% DISCOUNT AY SERVICES NOT LISTED ABOVE RECEIVE A MINIMUM 10% D st any additional upgraded services below b NOT bill for any services listed above.			
graded Services Names		Retail Charges	Patient's Responsibility
x. Amount to Charge to Fund:		125.00	
x. Amount to Charge to Member:		175.50	



Example #2: Retail value of single vision lens is \$49 and retail value of frame is \$70. No eye exam was performed. The total retail value is \$119 and total charge to fund would be \$119.

	GENERAL VISION SERVICES		
	Patient First Name: PETER Patient Last Name: FOND)A	
	Patient DOB: 07/07/1977		
	Member Infomation First Name PETE		Last Name FONDA
	Address 123 ANY		Last Name FONDA
	City BRONX		te Select ‡ Zip 10465-3
		Phone	
ertificate #:			88test019
ertificate #: ertificate Valid from Monday, September 19, 2016 through	Sunday December 18, 2016	•	octestu 19
ervice Date:	Sunday, Section 10, 2010		V V
FT Provider #:			
art 3 - Service(s) Provided (Check all that apply) And Enter R	letail Charges - REQUIRED ENTRY		
	-	Retail Charges	Patient's Responsibility
Single Vision Lens(es)	INCLUDED	49.00	0.00
Bifocal Lens(es)	INCLUDED		
Trifocal Lens(es)	INCLUDED		
Progressives	Min. 10% DISCOUNT		
Eye Exam (Max. Retail Price \$20)	INCLUDED		
Frame	\$125 ALLOWANCE Additional up to \$100 Credit For Upgraded Frames	70.00	0.00
Contact Lenses (CTL)	\$125 ALLOWANCE		
S.C.O.B. (see back of certificate)			
SS: WELFARE FUND BENEFIT			0.00
rcharges (Patient's Responsibility)			
-		Retail Charges	Patient's Responsibility
Tinting < 40%	Max. \$15.00 INCLUDED		
Tinting > 40% UV Block			
Scratch Resistant Coating	Max. \$15.00 Max. \$20.00		
Glare Free Coating	Max. \$30.00		
Eye Exam with Dilation	Max. \$30.00		
Polycarbonate	Max. \$35.00		
Photochromic	Max. \$50.00		
PPGRADED SERVICES - MINIMUM 10% DISCOUNT NY SERVICES NOT LISTED ABOVE RECEIVE A MINIMUM 10% DISCO st any additional upgraded services below o NOT bill for any services listed above.	DUNT		
ograded Services Names		Retail Charges	Patient's Responsibility
x. Amount to Charge to Fund:		119.0	0
x. Amount to Charge to Member:		0.0	0
ctual Amount to Charge to Fund: Provider to bill fund usua			



Example #3: Retail value of single vision lens is \$30, retail value of frame is \$50 and an exam was performed. The maximum you can bill the fund for an exam is \$20. The total charge to fund would be \$100.

G	S GENERAL VISION SERVICES		
	UFT Worksheet View Instructions Patient First Name: PETER Patient Last Name: FONDA		
	Patient DOB: 07/07/1977		
	First Name PETER	ember Infomation Last Name FO	NDA
	Address 123 ANY STREET	Last Name Pol	NDA
	City BRONX Phone	State Select	‡ Zip 10465-3
Certificate #:		88te:	st019
Certificate Valid from Monday, September 19, 2016 through Su	nday, December 18, 2016		
Service Date:			, <u> </u>
UFT Provider #:			
Part 3 - Service(s) Provided (Check all that apply) And Enter Reta	iil Charges - REQUIRED ENTRY		
.		Retail Charges	Patient's Responsibility
✓ Single Vision Lens(es)	INCLUDED	30.00	0.00
Bifocal Lens(es)	INCLUDED INCLUDED		
☐ Trifocal Lens(es) ☐ Progressives	Min. 10% DISCOUNT		
✓ Eye Exam (Max. Retail Price \$20)	INCLUDED	20.00	0.00
	\$125 ALLOWANCE		
▼ Frame	Additional up to \$100 Credit For Upgraded Frames	50.00	0.00
Contact Lenses (CTL)	\$125 ALLOWANCE		
S.C.O.B. (see back of certificate)			
LESS: WELFARE FUND BENEFIT			0.00
Surcharges (Patient's Responsibility)		Retail Charges	Patient's Responsibility
☐Tinting < 40%	Max. \$15.00		
☐Tinting > 40%	INCLUDED		
UV Block	Max. \$15.00		
Scratch Resistant Coating	Max. \$20.00		
Glare Free Coating	Max. \$30.00		
Eye Exam with Dilation	Max. \$30.00		
☐ Polycarbonate	Max. \$35.00		
□ Photochromic UPGRADED SERVICES - MINIMUM 10% DISCOUNT ANY SERVICES NOT LISTED ABOVE RECEIVE A MINIMUM 10% DISCOUN List any additional upgraded services below DO NOT bill for any services listed above.	Max. \$50.00 T	_	
Jpgraded Services Names		Retail Charges	Patient's Responsibility
fax. Amount to Charge to Fund:		100.00	
lax. Amount to Charge to Member:		0.00	
Actual Amount to Charge to Fund: Provider to bill fund usual a ENTERED ON CERTIFICATE)	nd customary or \$125. Whichever is less.(AMOUNT MUST BE	100.00	
Actual Amount to Charge to Member: (AMOUNT MUST BE ENTE		0.00	



Example #4: Eye exam was performed. The retail value of bifocal lenses is \$159 and the retail value of the frame is \$79. The retail value of all services is greater than \$125, so you would bill the fund for the full \$125 payment.

	GVS GENERAL VISION SERVICES		
	I SERVICES		
	UFT Worksheet View Instructions		
	Patient First Name: PETER Patient Last Name: FONDA Patient DOB: 07/07/1977	4	
	Mi	ember Infomation	
	First Name PETER	Last Name	ONDA
	Address 123 ANY STREET		
	City BRONX Phone	State Select	‡ Zip 10465-3
Certificate #:		88t	est019
Certificate Valid from Monday, September 19, 2016 t	hrough Sunday, December 18, 2016		
Service Date:			/
UFT Provider #:			
Part 3 - Service(s) Provided (Check all that apply) And	Enter Retail Charges - REQUIRED ENTRY		
		Retail Charges	Patient's Responsibility
Single Vision Lens(es)	INCLUDED		
✓ Bifocal Lens(es) ☐ Trifocal Lens(es)	INCLUDED INCLUDED	159.00	0.00
Progressives	Min. 10% DISCOUNT		
✓ Eye Exam (Max. Retail Price \$20)	INCLUDED	20.00	0.00
	\$125 ALLOWANCE		
✓ Frame	Additional up to \$100 Credit For Upgraded Frames	79.00	0.00
Contact Lenses (CTL)	\$125 ALLOWANCE		
S.C.O.B. (see back of certificate)			
LESS: WELFARE FUND BENEFIT			0.00
Surcharges (Patient's Responsibility)			
		Retail Charges	Patient's Responsibility
☐ Tinting < 40%	Max. \$15.00		
Tinting > 40%	INCLUDED		
UV Block	Max. \$15.00		
Scratch Resistant Coating Glare Free Coating	Max. \$20.00		
Eye Exam with Dilation	Max. \$30.00		
	Max. \$30.00		
Polycarbonate Photochromic	Max. \$35.00 Max. \$50.00		
UPGRADED SERVICES - MINIMUM 10% DISCOUNT ANY SERVICES NOT LISTED ABOVE RECEIVE A MINIMUM 10% List any additional upgraded services below Do NOT bill for any services listed above.			
Upgraded Services Names		Retail Charges	Patient's Responsibility
Max. Amount to Charge to Fund:		125.00	
Max. Amount to Charge to Member:		0.00	
	nd usual and customary or \$125. Whichever is less.(AMOUNT MUST BE		
ENTERED ON CERTIFICATE)	,	125.00	
A -t			



Example #5: No eye exam performed. Member ordered a year supply of contact lenses. The retail price was \$520. You applied the \$125 benefit, making the member charge \$395 out of pocket. The total charge to fund would be \$125.

	GVS GENERAL VISION SERVICES		
	SERVICES		
	UFT Worksheet View Instructions		
	Patient First Name: PETER Patient Last Name: FONDA		
	Patient DOB: 07/07/1977	Member Infomation	
	First Name PETER	Last Name FO	NDA
	Address 123 ANY STREET		
	City BRONX Phone	State Select	‡ Zip 10465-3
	FILL		
Certificate #:		88te	st019
Certificate Valid from Monday, September 19, 2016	through Sunday, December 18, 2016		
Service Date:			,
UFT Provider #:			
Part 3 - Service(s) Provided (Check all that apply) And	Enter Retail Charges - REQUIRED ENTRY	Retail Charges	Patient's Responsibility
☐ Single Vision Lens(es)	INCLUDED	Retail Ollarges	rations a responsibility
Bifocal Lens(es)	INCLUDED		
Trifocal Lens(es)	INCLUDED		
Progressives	Min. 10% DISCOUNT		
Eye Exam (Max. Retail Price \$20)	INCLUDED		
Frame	\$125 ALLOWANCE		
✓ Contact Lenses (CTL)	Additional up to \$100 Credit For Upgraded Frames \$125 ALLOWANCE	520.00	520.00
S.C.O.B. (see back of certificate)	¥125 /1225 // 1102	320.00	323.33
LESS: WELFARE FUND BENEFIT			-125.00
Surcharges (Patient's Responsibility)			
		Retail Charges	Patient's Responsibility
☐ Tinting < 40%	Max. \$15.00		
☐ Tinting > 40%	INCLUDED		
UV Block	Max. \$15.00		
Scratch Resistant Coating	Max. \$20.00		
☐ Glare Free Coating	Max. \$30.00		
Eye Exam with Dilation	Max. \$30.00		
Polycarbonate	Max. \$35.00		
□ Photochromic UPGRADED SERVICES - MINIMUM 10% DISCOUNT	Max. \$50.00		
ANY SERVICES NOT LISTED ABOVE RECEIVE A MINIMUM 10	% DISCOUNT		
List any additional upgraded services below			
Do NOT bill for any services listed above. Upgraded Services Names		Retail Charges	Patient's Responsibility
Max. Amount to Charge to Fund:		125.00	
Max. Amount to Charge to Member:		395.00	
Actual Amount to Charge to Fund: Provider to bill fu ENTERED ON CERTIFICATE)	nd usual and customary or \$125. Whichever is less.(AMOUNT MUST Bl	125.00	
Actual Amount to Charge to Member: (AMOUNT MUS	T BE ENTERED ON CERTIFICATE)	395.00	
	•		



S.C.O.B. Benefits:

Members and their spouse/domestic partner who are also members are entitled to special coordination of benefits (SCOB). Upon presentation of two (2) certificates, to two (2) covered services, *one service under each benefit record*.

When processing the following instructions need to be applied:

- On worksheet please check the S.C.O.B. section
- In window enter second voucher number
- Member will receive a credit of up to \$125 off of glasses
- Please send both vouchers when billing is completed

	GENERAL			
	GVS GENERAL VISION			
	SERVICES			
	UFT Worksheet	View Instructions		
	Patient First Name: BRIGIT Patient Last Name: FO	NDA		
	Patient DOB: 07/07/1997			
		Member Infomation		
	First Name BRIG		FONDA	
	Address 123 ANY	<u></u>		
	City BRONX	Phone State Select	‡) Zip 10465-	
		FIIONE		
Certificate #:		88tes	t004	
Certificate Valid from Monday, September 19, 2016 th	rough Sunday, December 18, 2016			
Service Date:			18 / 2016	
UFT Provider #:		2000191296		
Part 3 - Service(s) Provided (Check all that apply) And	Enter Retail Charges - REQUIRED ENTRY			
© Clark Malan Landon)		Retail Charges		Patient's Responsibility
Single Vision Lens(es) Rifered Lens(es)		99.00		0.00
Bifocal Lens(es) Trifocal Lens(es)	INCLUDED INCLUDED			
Trifocal Lens(es) Progressives	Min. 10% DISCOUNT			
Eye Exam (Max. Fund Reimbursement \$20)	INCLUDED	250.00		125.00
	\$100 ALLOWANCE	250.00		125.00
S.C.O.B. Certificate # 88test004	\$125 ALLOWANCE			
S.C.O.B. Certificate # Valid from Monday, September	19, 2016 through Sunday, December 18, 2016			
Member will receive up to \$125 additional credit town	ards total patient responsibility. Credit will display belo	w. A second worksheet will		
automatically be generated for this certificate.				0.00
LESS: WELFARE FUND BENEFIT				0.00
Surcharges (Patient's Responsibility)		Retail Charges		Patient's Responsibility
E Table - 404		Retail Charges		ratient's Responsibility
Tinting < 40%	Max. \$15.00			
☐Tinting > 40%	INCLUDED			
UV Block	Max. \$15.00			
Scratch Resistant Coating	Max. \$20.00			
Glare Free Coating	Max. \$30.00			
Eye Exam with Dilation	Max. \$30.00			
Polycarbonate	Max. \$35.00			
■ Photochromic	Max. \$50.00			
LIDCHARDER CERVICES MINIMUM 100/ DISCOUNT				
UPGRADED SERVICES - MINIMUM 10% DISCOUNT ANY SERVICES NOT LISTED ABOVE RECEIVE A MINIMUM 10%	DISCOUNT			
List any additional upgraded services below				
Do NOT bill for any services listed above.		B - 1 - 11 Ob		B-1/
Upgraded Services Names - Select -		Retail Charges		Patient's Responsibility
- Select - ‡				
- Select - 💠				
- Select - \$				
LESS S.C.O.B. WELFARE FUND BENEFIT				
Max. Amount to Charge to Fund:			0.00	
Max. Amount to Charge to Member:			0.00	
	nd usual and customary or \$125. Whichever is less.(AMG	OLINT MUST BE ENTEDED ON		
CERTIFICATE)	a assau and customary or \$125. Willeliever is less.(AMC	JOHN PROST DE ENTERED ON		
Actual Amount to Charge to Member: (AMOUNT MUS	BE ENTERED ON CERTIFICATE)			
				alculate Worksheet
				Print Worksheet Print S.C.O.B. Worksheet
				Submit Worksheet Print S.C.O.B. Worksheet
			3	AUDITIC TOTASTICEL



Submit Worksheet:

- 1. When all entries have been made, please click **Calculate Worksheet**.
- 2. Please print a copy of the worksheet by clicking the **Print Worksheet** button.
- 3. If applicable, click **Print S.C.O.B. Worksheet**.
- 4. Once completed, review all of the information to make sure it is correct and then click **Submit Worksheet**.
- 5. A window will appear confirming that you submitted the worksheet.
- 6. You must send in the original UFT Certificate for payment. Please fax your certificates to 1-212-729-5381 or mail to GVS, UFT Division, PO Box 731, New York, NY 10018.

Г	- LOENEDA			
	GENERA VISION	L		
	SERVICE	S		
	UFT Work		ructions	
	atient First Name: BRIGIT Patient La: Patient DOB: 07/07/19	st Name: FONDA 97		
		Member Infomation	1	
	First Name BRIGIT	Las	t Name FONDA	
	Address 123 ANY STREET City BRONX	State	Select	
		Phone	Select # 21p 10465-3	
Certificate #:		88test004		
Certificate Valid from Monday, September 19, 2016 through Sunday, December	18, 2016	11 / 10 /	2015	
Service Date:	7000101705	11 / 18 /	2016	
UFT Provider #:	2000191296			
Part 3 - Service(s) Provided (Check all that apply) And Enter Retail Charges - REQU	JIRED ENTRY			
● Single Vision Lens(es)	INCLUDED	Retail Charges 99.00		Patient's Responsibility 0.00
Bifocal Lens(es)	INCLUDED	23.00		
○ Trifocal Lens(es)	INCLUDED		Charges	
O Progressives	Min. 10% DISCOUNT			
Eye Exam (Max. Fund Reimbursement \$20)	INCLUDED			
✓ Frame	\$100 ALLOWANCE	250.00		125.00
Contact Lenses (CTL)	\$125 ALLOWANCE			
S.C.O.B. Certificate # 88test004				
S.C.O.B. Certificate # Valid from Monday, September 19, 2016 through Sunday, Member will receive up to \$125 additional credit towards total patient responsi be generated for this certificate.		cond worksheet will a	nutomatically	
LESS: WELFARE FUND BENEFIT				-125.00
Surcharges (Patient's Responsibility)		Retail Charges		Patient's Responsibility
C Tinking a 400/		Retail Ollarges		rations of Responsibility
Tinting < 40%	Max. \$15.00			
Tinting > 40%	INCLUDED			
UV Block Scratch Resistant Coating	Max. \$15.00 Max. \$20.00			
Glare Free Coating	Max. \$30.00			
Eye Exam with Dilation	Max. \$30.00			
Polycarbonate	Max. \$35.00		tcg-nyvwd-01 says	:
Photochromic	Max. \$50.00	5.	Your claim has been proc	essed. You MUST send in
		•		
UPGRADED SERVICES - MINIMUM 10% DISCOUNT			Original UFT Certficate to	receive payment.
ANY SERVICES NOT LISTED ABOVE RECEIVE A MINIMUM 10% DISCOUNT				
List any additional upgraded services below Do NOT bill for any services listed above.				04
Upgraded Services Names				OK
- Select - \$				
- Select - +				
- Select - + + - + - + + - + - + - + + - + - +				
•				
LESS S.C.O.B. WELFARE FUND BENEFIT				0
Max. Amount to Charge to Fund:			125.00	
Max. Amount to Charge to Member:			0.00	
	#13E Whichever is less (ANOVY)	HET DE ENTERER OU		
Actual Amount to Charge to Fund: Provider to bill fund usual and customary or Actual Amount to Charge to Member: (AMOUNT MUST BE ENTERED ON CERTIFI		UST BE ENTERED ON	CERTIFICATE) 125	
Actual Amount to Charge to Member: (AMOUNT MUST BE ENTERED ON CERTIFI	CATE			
				ulate Worksheet
				nt Worksheet 3 Print S.C.O.B. Worksheet
			4 . Sub	mit Worksheet