




# UFT Training Manual




## Logging into the GVS Billing Website:


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





GENERAL VISION SERVICES

Vision Care Beyond Compare










UFT  
Welfare Fund



Select an option below to learn more about the advantages of GVS

► PLAN MEMBERS

To obtain nearest provider

GO

► PLAN ADMINISTRATORS

To obtain claim information and reports

GO

► PLAN PROVIDERS

To file a claim

GO

**FIND A UFT PROVIDER IN YOUR AREA**

ZIP CODE

3 ▾ LOCATIONS

SUBMIT



## Logging into the GVS Billing Website:

1. Enter your: **Username**
2. Enter your: **Password**
3. Click **Log In**



#### User Login

User ID



Password




© 2016 GVSS

[Change Password](#)

**LOG IN**

1. Click: **File Claims**



ADMINISTERED BY  
**GVS**  
GENERAL VISION SERVICES

**Please Select From the available options**


File Claims

Report

Claim Inquiry


Lookup ICD-10 Codes

[Back](#) | [Home](#)

  
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1. Select: **Option 2**  
Enter: **UFT Certificate Number**  
Click: **Submit**
2. View instructions for claim submission [here](#).





ADMINISTERED BY  
**GVS**  
GENERAL VISION SERVICES

Select 1 of the Available Claim Options

Option 1

UFT Certificate Number


88test008

2. [View Instructions](#)

1. [Submit](#)

\* Enter: UFT Certificate Number.

[\[Back\]](#) [Main Menu](#)

  
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## 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.
2. Enter: **Actual Amount to Charge to Fund** and **Actual Amount to Charge to Member** at the bottom of the form.



UFT Worksheet

View Instructions

Patient First Name: PETER Patient Last Name: FONDA  
Patient DOB: 07/07/1977

## Member Information

First Name PETER

Last Name FONDA

Address 123 ANY STREET

City BRONX

State Select

Zip 10465-3

Phone

## Certificate #:

88test019

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
<input checked="" type="checkbox"/> Single Vision Lens(es)	INCLUDED	49.00	0.00
<input type="checkbox"/> Bifocal Lens(es)	INCLUDED		
<input type="checkbox"/> Trifocal Lens(es)	INCLUDED		
<input type="checkbox"/> Progressives	Min. 10% DISCOUNT		
<input type="checkbox"/> Eye Exam (Max. Retail Price \$20)	INCLUDED		
<input checked="" type="checkbox"/> Frame	\$125 ALLOWANCE Additional up to \$100 Credit For Upgraded Frames	70.00	0.00
<input type="checkbox"/> Contact Lenses (CTL)	\$125 ALLOWANCE		
<input type="checkbox"/> S.C.O.B. (see back of certificate)			
<b>LESS: WELFARE FUND BENEFIT</b>			<b>0.00</b>

## Surcharges (Patient's Responsibility)

		Retail Charges	Patient's Responsibility
<input type="checkbox"/> Tinting < 40%	Max. \$15.00		
<input type="checkbox"/> Tinting > 40%	INCLUDED		
<input type="checkbox"/> UV Block	Max. \$15.00		
<input type="checkbox"/> Scratch Resistant Coating	Max. \$20.00		
<input type="checkbox"/> Glare Free Coating	Max. \$30.00		
<input type="checkbox"/> Eye Exam with Dilation	Max. \$30.00		
<input type="checkbox"/> Polycarbonate	Max. \$35.00		
<input type="checkbox"/> 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



Max. Amount to Charge to Fund:

119.00

Max. 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.(AMOUNT MUST BE ENTERED ON CERTIFICATE)

119.00

Actual Amount to Charge to Member: (AMOUNT MUST BE ENTERED ON CERTIFICATE)

0.00

## UFT Formula Samples:

### Example #1:

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



UFT Worksheet

View Instructions

Patient First Name: JANE Patient Last Name: FONDA  
Patient DOB: 07/07/1987

## Member Information

First Name JANE

Last Name FONDA

Address 123 ANY STREET

City BRONX

State Select

Zip 10465-3

Phone

## Certificate #:

88test020

Certificate Valid from Monday, September 19, 2016 through Sunday, December 18, 2016

Service Date:

10 / 13 / 2016

UFT Provider #:

## Part 3 - Service(s) Provided (Check all that apply) And Enter Retail Charges - REQUIRED ENTRY

		Retail Charges	Patient's Responsibility
<input type="checkbox"/> Single Vision Lens(es)	INCLUDED		
<input type="checkbox"/> Bifocal Lens(es)			
<input type="checkbox"/> Trifocal Lens(es)	INCLUDED		
<input checked="" type="checkbox"/> Progressives	Min. 10% DISCOUNT	225.00	202.50
<input type="checkbox"/> Eye Exam (Max. Retail Price \$20)	INCLUDED		
<input checked="" type="checkbox"/> Frame	\$125 ALLOWANCE Additional up to \$100 Credit For Upgraded Frames	220.00	98.00
<input type="checkbox"/> Contact Lenses (CTL)	\$125 ALLOWANCE		
<input type="checkbox"/> S.C.O.B. (see back of certificate)			
<b>LESS: WELFARE FUND BENEFIT</b>			<b>-125.00</b>

## Surcharges (Patient's Responsibility)

		Retail Charges	Patient's Responsibility
<input type="checkbox"/> Tinting < 40%	Max. \$15.00		
<input type="checkbox"/> Tinting > 40%	INCLUDED		
<input type="checkbox"/> UV Block	Max. \$15.00		
<input type="checkbox"/> Scratch Resistant Coating	Max. \$20.00		
<input type="checkbox"/> Glare Free Coating	Max. \$30.00		
<input type="checkbox"/> Eye Exam with Dilation	Max. \$30.00		
<input type="checkbox"/> Polycarbonate	Max. \$35.00		
<input type="checkbox"/> 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



Max. Amount to Charge to Fund:

125.00

Max. Amount to Charge to Member:

175.50

Actual Amount to Charge to Fund: Provider to bill fund usual and customary or \$125. Whichever is less. (AMOUNT MUST BE ENTERED ON CERTIFICATE)

125.00

Actual Amount to Charge to Member: (AMOUNT MUST BE ENTERED ON CERTIFICATE)

175.50

### UFT Formula Samples:

**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.



UFT Worksheet

View Instructions

Patient First Name: PETER Patient Last Name: FONDA  
Patient DOB: 07/07/1977

## Member Information

First Name PETER Last Name FONDA  
Address 123 ANY STREET  
City BRONX State Select Zip 10465-3  
Phone

## Certificate #:

88test019

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
<input checked="" type="checkbox"/> Single Vision Lens(es)	INCLUDED	49.00	0.00
<input type="checkbox"/> Bifocal Lens(es)	INCLUDED		
<input type="checkbox"/> Trifocal Lens(es)	INCLUDED		
<input type="checkbox"/> Progressives	Min. 10% DISCOUNT		
<input type="checkbox"/> Eye Exam (Max. Retail Price \$20)	INCLUDED		
<input checked="" type="checkbox"/> Frame	\$125 ALLOWANCE Additional up to \$100 Credit For Upgraded Frames	70.00	0.00
<input type="checkbox"/> Contact Lenses (CTL)	\$125 ALLOWANCE		
<input type="checkbox"/> S.C.O.B. (see back of certificate)			
<b>LESS: WELFARE FUND BENEFIT</b>			<b>0.00</b>

## Surcharges (Patient's Responsibility)

		Retail Charges	Patient's Responsibility
<input type="checkbox"/> Tinting < 40%	Max. \$15.00		
<input type="checkbox"/> Tinting > 40%	INCLUDED		
<input type="checkbox"/> UV Block	Max. \$15.00		
<input type="checkbox"/> Scratch Resistant Coating	Max. \$20.00		
<input type="checkbox"/> Glare Free Coating	Max. \$30.00		
<input type="checkbox"/> Eye Exam with Dilation	Max. \$30.00		
<input type="checkbox"/> Polycarbonate	Max. \$35.00		
<input type="checkbox"/> 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

Max. Amount to Charge to Fund:

119.00

Max. 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.(AMOUNT MUST BE ENTERED ON CERTIFICATE)

119.00

Actual Amount to Charge to Member: (AMOUNT MUST BE ENTERED ON CERTIFICATE)

0.00



### UFT Formula Samples:

**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.



UFT Worksheet

View Instructions

Patient First Name: PETER Patient Last Name: FONDA  
Patient DOB: 07/07/1977

## Member Information

First Name PETER

Last Name FONDA

Address 123 ANY STREET

City BRONX

State Select

Zip 10465-3

Phone

## Certificate #:

88test019

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
<input checked="" type="checkbox"/> Single Vision Lens(es)	INCLUDED	30.00	0.00
<input type="checkbox"/> Bifocal Lens(es)	INCLUDED		
<input type="checkbox"/> Trifocal Lens(es)	INCLUDED		
<input type="checkbox"/> Progressives	Min. 10% DISCOUNT		
<input checked="" type="checkbox"/> Eye Exam (Max. Retail Price \$20)	INCLUDED	20.00	0.00
<input checked="" type="checkbox"/> Frame	\$125 ALLOWANCE Additional up to \$100 Credit For Upgraded Frames	50.00	0.00
<input type="checkbox"/> Contact Lenses (CTL)	\$125 ALLOWANCE		
<input type="checkbox"/> S.C.O.B. (see back of certificate)			
<b>LESS: WELFARE FUND BENEFIT</b>			<b>0.00</b>

## Surcharges (Patient's Responsibility)

		Retail Charges	Patient's Responsibility
<input type="checkbox"/> Tinting < 40%	Max. \$15.00		
<input type="checkbox"/> Tinting > 40%	INCLUDED		
<input type="checkbox"/> UV Block	Max. \$15.00		
<input type="checkbox"/> Scratch Resistant Coating	Max. \$20.00		
<input type="checkbox"/> Glare Free Coating	Max. \$30.00		
<input type="checkbox"/> Eye Exam with Dilation	Max. \$30.00		
<input type="checkbox"/> Polycarbonate	Max. \$35.00		
<input type="checkbox"/> 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


Max. Amount to Charge to Fund:

100.00

Max. 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.(AMOUNT MUST BE ENTERED ON CERTIFICATE)

100.00

Actual Amount to Charge to Member: (AMOUNT MUST BE ENTERED ON CERTIFICATE)

0.00

## UFT Formula Samples:

**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.



UFT Worksheet

View Instructions

Patient First Name: PETER Patient Last Name: FONDA  
Patient DOB: 07/07/1977

## Member Information

First Name PETER

Last Name FONDA

Address 123 ANY STREET

City BRONX

State Select

Zip 10465-3

Phone

## Certificate #:

88test019

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
<input type="checkbox"/> Single Vision Lens(es)	INCLUDED		
<input checked="" type="checkbox"/> Bifocal Lens(es)	INCLUDED	159.00	0.00
<input type="checkbox"/> Trifocal Lens(es)	INCLUDED		
<input type="checkbox"/> Progressives	Min. 10% DISCOUNT		
<input checked="" type="checkbox"/> Eye Exam (Max. Retail Price \$20)	INCLUDED	20.00	0.00
<input checked="" type="checkbox"/> Frame	\$125 ALLOWANCE Additional up to \$100 Credit For Upgraded Frames	79.00	0.00
<input type="checkbox"/> Contact Lenses (CTL)	\$125 ALLOWANCE		
<input type="checkbox"/> S.C.O.B. (see back of certificate)			
<b>LESS: WELFARE FUND BENEFIT</b>			<b>0.00</b>

## Surcharges (Patient's Responsibility)

		Retail Charges	Patient's Responsibility
<input type="checkbox"/> Tinting < 40%	Max. \$15.00		
<input type="checkbox"/> Tinting > 40%	INCLUDED		
<input type="checkbox"/> UV Block	Max. \$15.00		
<input type="checkbox"/> Scratch Resistant Coating	Max. \$20.00		
<input type="checkbox"/> Glare Free Coating	Max. \$30.00		
<input type="checkbox"/> Eye Exam with Dilation	Max. \$30.00		
<input type="checkbox"/> Polycarbonate	Max. \$35.00		
<input type="checkbox"/> 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



Max. Amount to Charge to Fund:

125.00

Max. 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.(AMOUNT MUST BE ENTERED ON CERTIFICATE)

125.00

Actual Amount to Charge to Member: (AMOUNT MUST BE ENTERED ON CERTIFICATE)

0.00



## UFT Formula Samples:

**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.



UFT Worksheet

View Instructions

Patient First Name: PETER Patient Last Name: FONDA  
Patient DOB: 07/07/1977

## Member Information

First Name PETER

Last Name FONDA

Address 123 ANY STREET

City BRONX

State Select

Zip 10465-3

Phone

## Certificate #:

88test019

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
<input type="checkbox"/> Single Vision Lens(es)	INCLUDED		
<input type="checkbox"/> Bifocal Lens(es)	INCLUDED		
<input type="checkbox"/> Trifocal Lens(es)	INCLUDED		
<input type="checkbox"/> Progressives	Min. 10% DISCOUNT		
<input type="checkbox"/> Eye Exam (Max. Retail Price \$20)	INCLUDED		
<input type="checkbox"/> Frame	\$125 ALLOWANCE		
	Additional up to \$100 Credit For Upgraded Frames		
<input checked="" type="checkbox"/> Contact Lenses (CTL)	\$125 ALLOWANCE	520.00	520.00
<input type="checkbox"/> S.C.O.B. (see back of certificate)			
<b>LESS: WELFARE FUND BENEFIT</b>			<b>-125.00</b>

## Surcharges (Patient's Responsibility)

		Retail Charges	Patient's Responsibility
<input type="checkbox"/> Tinting < 40%	Max. \$15.00		
<input type="checkbox"/> Tinting > 40%	INCLUDED		
<input type="checkbox"/> UV Block	Max. \$15.00		
<input type="checkbox"/> Scratch Resistant Coating	Max. \$20.00		
<input type="checkbox"/> Glare Free Coating	Max. \$30.00		
<input type="checkbox"/> Eye Exam with Dilation	Max. \$30.00		
<input type="checkbox"/> Polycarbonate	Max. \$35.00		
<input type="checkbox"/> 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


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 fund usual and customary or \$125. Whichever is less. (AMOUNT MUST BE ENTERED ON CERTIFICATE)

125.00

Actual Amount to Charge to Member: (AMOUNT MUST 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





UFT Worksheet

View Instructions

Patient First Name: BRIGIT Patient Last Name: FONDA  
Patient DOB: 07/07/1997

## Member Information

First Name BRIGIT Last Name FONDA  
Address 123 ANY STREET  
City BRONX State  Zip 10465-  
Phone

## Certificate #:

88test004

Certificate Valid from Monday, September 19, 2016 through Sunday, December 18, 2016

Service Date:

11 / 18 / 2016

UFT Provider #:

2000191296

## Part 3 - Service(s) Provided (Check all that apply) And Enter Retail Charges - REQUIRED ENTRY

		Retail Charges	Patient's Responsibility
<input type="radio"/> Single Vision Lens(es)		99.00	0.00
<input type="radio"/> Bifocal Lens(es)	INCLUDED		
<input type="radio"/> Trifocal Lens(es)	INCLUDED		
<input type="radio"/> Progressives	Min. 10% DISCOUNT		
<input type="checkbox"/> Eye Exam (Max. Fund Reimbursement \$20)	INCLUDED		
<input checked="" type="checkbox"/> Frame	\$100 ALLOWANCE	250.00	125.00
<input type="checkbox"/> Contact Lenses (CTL)	\$125 ALLOWANCE		
<input checked="" type="checkbox"/> S.C.O.B. Certificate # 88test004			

S.C.O.B. Certificate # Valid from Monday, September 19, 2016 through Sunday, December 18, 2016

Member will receive up to \$125 additional credit towards total patient responsibility. Credit will display below. A second worksheet will automatically be generated for this certificate.

LESS: WELFARE FUND BENEFIT

0.00

## Surcharges (Patient's Responsibility)

		Retail Charges	Patient's Responsibility
<input type="checkbox"/> Tinting < 40%	Max. \$15.00		
<input type="checkbox"/> Tinting > 40%	INCLUDED		
<input type="checkbox"/> UV Block	Max. \$15.00		
<input type="checkbox"/> Scratch Resistant Coating	Max. \$20.00		
<input type="checkbox"/> Glare Free Coating	Max. \$30.00		
<input type="checkbox"/> Eye Exam with Dilation	Max. \$30.00		
<input type="checkbox"/> Polycarbonate	Max. \$35.00		
<input type="checkbox"/> 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

- Select -
- Select -
- Select -
- Select -
- Select -
- Select -
- Select -
- Select -
- Select -
- Select -

## Retail Charges

## Patient's Responsibility


## LESS S.C.O.B. WELFARE FUND BENEFIT

Max. Amount to Charge to Fund:

0.00

Max. 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.(AMOUNT MUST BE ENTERED ON CERTIFICATE)

Actual Amount to Charge to Member: (AMOUNT MUST BE ENTERED ON CERTIFICATE)

Calculate Worksheet

Print Worksheet

Print S.C.O.B. Worksheet

Submit Worksheet



## 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.**



