

# Vision Claim Form



| Part 1. To Be Completed and Signed by Employee (Please Print)  |  |  |  |  |   |
|--|--|--|--|--|---|
| EMPLOYEE'S NAME (FIRST) (LAST)   |  | EMPLOYEE'S BIRTH DATE  | NAME OF COMPANY YOU WORK FOR (FIRM NAME)                 |  | LOCAL UNION NO.   |
| HOME ADDRESS (NUMBER AND STREET)   |  |  | DATE EMPLOYED  | OCCUPATION   |   |
| (CITY) (STATE) (ZIP CODE)  |  | HOME TELEPHONE NO.   |  | SUBSCRIBER NO.   |   |
| CLAIM IS MADE FOR  | <input type="checkbox"/> SELF<br><input type="checkbox"/> SPOUSE<br><input type="checkbox"/> CHILD | NAME OF PERSON RECEIVING VISION CARE (FIRST) (LAST)                                |  | PERSON RECEIVING VISION CARE<br><input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE   | DATE OF BIRTH OF PERSON RECEIVING VISION CARE   |
| NAME AND ADDRESS OF SPOUSE'S EMPLOYER  |  |  |  | SPOUSE'S BIRTH DATE  | DOES SPOUSE HAVE VISION INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| NAME OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR VISION CARE (INCLUDING DEPENDENTS' INSURANCE)                               |  |  |  |  |   |
| WAS VISION CARE REQUIRED BECAUSE OF AN INJURY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF "YES," COMPLETE QUESTIONS BELOW. |  |  |  |  |   |
| WAS INJURY CAUSED BY YOUR WORK?  | <input type="checkbox"/> YES <input type="checkbox"/> NO   | HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKERS' COMPENSATION CARRIER? | <input type="checkbox"/> YES <input type="checkbox"/> NO | IS VISION EXAMINATION REQUIRED AS A CONDITION OF YOUR EMPLOYMENT?  | <input type="checkbox"/> YES <input type="checkbox"/> NO                                    |
| Insured Must Sign Authorization on Reverse Side  |  |  |  | I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.<br><br>SIGNED (Insured or Authorized Person) |   |

## Part 2. To Be Completed by Doctor

- Has patient worn eyeglasses before this examination? \_\_\_\_\_ Type \_\_\_\_\_  
If "Yes," state reason for replacement \_\_\_\_\_
- If you prescribed eyeglasses, check type: Single Vision \_\_\_\_\_ Bifocal \_\_\_\_\_ Trifocal \_\_\_\_\_ Other (Describe) \_\_\_\_\_
- Has cataract surgery been performed? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_
- Can visual acuity be restored to at least 20/70 in the better eye with conventional eyeglasses? \_\_\_\_\_
- Are existing frames being used for the new eyeglasses?  Yes  No If "No," why not? \_\_\_\_\_

| FOR ADM USE ONLY                                | INS. CLASS | DEGREE           | DOCTOR LIC. NO.  | CLMT.  | STATE TRT.                  | ZIP TREATED             | ICDA                                  | CPT | AUDITOR NO. | DATE OF AUDIT       |               |
|---|------------|------------------|------------------|--------|-----------------------------|-------------------------|---------------------------------------|-----|-------------|---------------------|---------------|
| EMPLOYEE (LAST-FIRST-ZIP) _____ / _____ / _____ |            |                  |                  |        |                             | DATE OF BIRTH _____     | DEPENDENT NAME AND RELATIONSHIP _____ |     |             | DATE OF BIRTH _____ | COV. <b>V</b> |
| PROFESSIONAL SERVICES                           |            | DATES OF SERVICE | AMOUNT OF CHARGE |        | FOR ADMINISTRATION USE ONLY |                         |                                       |     |             |                     |               |
| VISION SURVEY                                   | 1A         |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| VISUAL EXAM W/O TONOM.                          | 1B         |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| VISUAL EXAM W/TONOM.                            | 1C         |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| SINGLE VISION LENSES                            | 1D         |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| BIFOCAL LENSES                                  | 1E         |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| TRIFOCAL LENSES                                 | 1F         |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| LENTICULAR LENSES                               | 1G         |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| CONTACTS, EACH LENS                             | 1H         |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| FRAME SERVICE                                   | 1J         |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| OTHER   |            |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| OTHER   |            |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| ATTACH ITEMIZED BILLS                           |            |                  | Subtotal         |        |                             |                         |                                       |     |             |                     |               |
|   |            |                  | Tax              |        |                             |                         |                                       |     |             |                     |               |
|   |            |                  | TOTAL            |        |                             |                         |                                       |     |             |                     |               |
| COORDINATION OF BENEFITS                        |            |                  |                  |        |                             |                         |                                       |     |             |                     |               |
| 80  | TYPE       | AMOUNT CHARGE    | AMOUNT           | C.O.B. | BALANCE DUE                 | No. of Dfts. This Audit |                                       |     |             |                     |               |

## Part 3. To Be Completed by Administrator

- Was the employee eligible for insurance and was insurance in force at time this claim commenced?  
 Yes  No
  - Months eligible \_\_\_\_\_
  - Date \_\_\_\_\_
- Signed \_\_\_\_\_

SIGNATURE BY THE DOCTOR CERTIFIES THAT ALL SERVICES LISTED ABOVE HAVE BEEN COMPLETED.

Date \_\_\_\_\_ Signed \_\_\_\_\_ (DOCTOR)


Individual Practitioners – SS No. \_\_\_\_\_  
All Others – Employer I.D. No. \_\_\_\_\_


(TYPE OR PRINT DOCTOR'S NAME) (DEGREE) License No. \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_ (NUMBER AND STREET) (CITY) (STATE) (ZIP CODE)



Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.

Date \_\_\_\_\_ Signature of Claimant (if not a minor) \_\_\_\_\_ 

Date \_\_\_\_\_ Signature of Insured \_\_\_\_\_ 

Policy No. \_\_\_\_\_ Employer \_\_\_\_\_

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Mail Claims to:  
The address on your  
Identification Card