

Vision Care Benefits Statement

PART A – TO BE COMPLETED BY EMPLOYEE

1. EMPLOYEE'S NAME (Last, First, Middle)		2. EMPLOYEE'S SOCIAL SECURITY NUMBER		3. DATE ISSUED		4. INVALID AFTER		
5. PATIENT'S NAME (Last, First, Middle)			6. PATIENT'S RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Student <input type="checkbox"/> Spouse <input type="checkbox"/> Handicapped <input type="checkbox"/> Other			7. PATIENT'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		8. PATIENT'S DATE OF BIRTH
9. EMPLOYEE'S ADDRESS (No., Street, City, State and Zip Code)				10. TELEPHONE No. ()		11. EMPLOYEE'S STATUS <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried		
12. EMPLOYER'S NAME AND ADDRESS								
13. IS PATIENT COVERED FOR VISION CARE BY ANOTHER PLAN? No <input type="checkbox"/> Yes <input type="checkbox"/>		VISION PLAN NAME		GROUP No.		NAME AND ADDRESS OF CARRIER		
14. IF CLAIM IS DUE TO ACCIDENT, INDICATE DATE, TIME, PLACE AND HOW ACCIDENT OCCURRED							15. DID ACCIDENT OCCUR AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. I HEREBY AUTHORIZE any Insurance Company, Organization, Employer, Ophthalmologist, Optometrist, and Optician to release any information with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct.				SIGNATURE OF EMPLOYEE _____		(DATE SIGNED) _____		
				ALSO, SIGNATURE OF DEPENDENT (If Patient, and Not a Minor) _____		(DATE SIGNED) _____		
17. I HEREBY AUTHORIZE payment directly to the Doctor and/or Dispenser <input type="checkbox"/> Yes <input type="checkbox"/> No of the Vision Care Benefits otherwise payable to me.				SIGNED (EMPLOYEE) _____		(DATE) _____		

PART B – TO BE COMPLETED BY DOCTOR

1. PLEASE CHECK ONE: <input type="checkbox"/> Non-Participating <input type="checkbox"/> Participating <input type="checkbox"/> Number _____			DATE ISSUED		INVALID AFTER	
2. DOCTOR'S NAME (Last, First, Middle)			3. TAXPAYER IDENTIFICATION No.		PROFESSIONAL SERVICES	
4. DOCTOR'S ADDRESS (No., Street, City, State and Zip Code)					AMOUNT	
5. PHONE No. (& Area Code) ()		6. TITLE <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> O.D.	7. EXAMINATION DATE(S)		8. HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSES? <input type="checkbox"/> Yes <input type="checkbox"/> No			10. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? <input type="checkbox"/> Yes <input type="checkbox"/> No		EXAMINATION CHARGE	
					TONOMETRY	
					TOTAL	
					AMOUNT PAID BY PATIENT	
11. DIAGNOSTIC CODE(S) _____			12. INDICATE DIAGNOSIS OR NATURE OF DISEASE OR INJURY OR VISION DISORDER, INDICATE PROCEDURE CODE Nos.		13. VISUAL ACUITY CORRECTED TO:	

14. DOCTOR'S PRESCRIPTION					15. I hereby certify that I have performed the services as indicated hereon.		
Sphere	Cylinder	Axis	Prism	Base	DOCTOR'S SIGNATURE _____		
R.E.	•	•			DATE _____		
L.E.	•	•			I certify that I have received the services described hereon.		
READING ADD	R.E.	+	•	L.E.	+	•	SIGNATURE (Employee, Spouse, Patient) _____
							DATE _____

PART C – TO BE COMPLETED BY DISPENSER

IN LIEU OF DISPENSER COMPLETING THIS SECTION A LABORATORY BILL CAN BE ATTACHED. DISPENSER MUST SIGN THIS FORM, ENTER AMOUNT PAID BY PATIENT.

1. PLEASE CHECK ONE: <input type="checkbox"/> Non-Participating <input type="checkbox"/> Participating <input type="checkbox"/> Number _____			DATE ISSUED		INVALID AFTER	
2. DISPENSER'S NAME (Last, First, Middle)			3. TAXPAYER IDENTIFICATION No.		PROFESSIONAL SERVICES	
4. DISPENSER'S ADDRESS (No., Street, City, State and Zip Code)			5. PHONE No. (& Area Code) ()		AMOUNT	
6. DISPENSER'S TITLE <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optician <input type="checkbox"/> Optometrist		7. MATERIALS SUPPLIED Tint No. _____ <input type="checkbox"/> Oversized <input type="checkbox"/> Glass <input type="checkbox"/> Plastic <input type="checkbox"/> Pair <input type="checkbox"/> 1/2 Pair <input type="checkbox"/> Other _____			8. DATE Order Delivery	
9. TYPE OF LENSES DISPENSED <input type="checkbox"/> None <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular <input type="checkbox"/> Contacts <input type="checkbox"/> Other (Specify) _____			10. CONTACT LENSES (If Contact Lenses, Please Complete) <input type="checkbox"/> Non-Therapeutic <input type="checkbox"/> Hard Lenses <input type="checkbox"/> Soft Lenses		11. FRAME MODEL OR CAT. No. & SIZE	
					12. FRAME MFT. NAME	
13. I hereby certify that I have performed the services as indicated hereon.					SALES TAX (If Any)	
DISPENSER'S SIGNATURE _____					DATE _____	
I certify that I have received the materials described hereon.					TOTAL	
SIGNATURE (Employee, Spouse, Patient) _____					AMOUNT PAID BY PATIENT	
					DATE _____	