



# HEALTH SYSTEMS

REFER TO YOUR I.D. CARD FOR PROPER MAILING ADDRESS

EMPLOYEE ID NUMBER

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## VISION CLAIM FORM

### PATIENT AND EMPLOYEE INFORMATION

1. PATIENT'S NAME		2. PATIENT'S DATE OF BIRTH		3. EMPLOYEE'S NAME	
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. EMPLOYEE'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	
		7. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		<input type="checkbox"/> CHECK HERE IF NEW ADDRESS	
8. OTHER HEALTH INSURANCE COVERAGE IS PATIENT COVERED BY ANY OTHER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER: _____					
IDENTIFICATION NUMBER _____ NAME OF EMPLOYER _____					
TYPES OF COVERAGE BY CARRIER: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DRUG <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION					
EFFECTIVE DATE OF COVERAGE _____ TERMINATION DATE OF COVERAGE _____					
9. IS THIS CONDITION CAUSED BY EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			10. DOES CLAIM INVOLVE AN INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/> WAS INJURED PERSON AT WORK? YES <input type="checkbox"/> NO <input type="checkbox"/> DATE AND TIME OF INJURY _____		
11. I AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.			12. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW.		
SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____			SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____		

### TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST ONLY

1. IS THIS A CHANGE IN PRESCRIPTION? .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. ARE THE LENSES OR FRAMES FOR EITHER SUNGLASSES OR OTHER NON-CORRECTIVE PURPOSES? .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. ARE NEW LENSES OR FRAMES FOR: DUPLICATION OF EXISTING ITEMS? .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
REPLACEMENT OF LOST OR BROKEN LENSES? .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
REPLACEMENT OF BROKEN FRAMES? .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. WERE THESE VISION CARE SERVICES REQUIRED AS A CONDITION OF THE PATIENT'S EMPLOYMENT? .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. TYPE OF LENSES PRESCRIBED:	<input type="checkbox"/> SINGLE VISION <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> LENTICULAR <input type="checkbox"/> BIFOCAL <input type="checkbox"/> PROGRESSIVE <input type="checkbox"/> CONTACTS	

DATE(S) OF SERVICE	SERVICE / PROCEDURE	DIAGNOSIS	CHARGE

DATE	SIGNATURE (ATTENDING DOCTOR)	DEGREE	FED. TAX NO.	TELEPHONE
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STREET ADDRESS	CITY OR TOWN	STATE	ZIP CODE
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