



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

EMPLOYEE ID NUMBER

$$\boxed{} \quad \boxed{} \quad \boxed{} - \boxed{} \quad \boxed{} \quad \boxed{} \quad \boxed{}$$

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

DATE SIGNATURE (ATTENDING DOCTOR) DEGREE FED. TAX NO. TELEPHONE

STREET ADDRESS _____ **CITY OR TOWN** _____ **STATE** _____ **ZIP CODE** _____