Bas

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VISION CLAIM FORM

Questions? Call Toll Free: 1.800.523.0582

INSTRUCTIONS: Complete a separate form for each family member for whom you are claiming expenses. Attach bills for each expense or have your provider of service complete the section on the back of this form.

Mail completed form to the address on the back of your insurance card.

EMPLOYEE & EMPLOYER INFORMATION

Employer Name: _____ **Group #:** _____ **Member ID#:** _____ **SSN:** _____

Employee Name: _____ **Home Phone:** _____ **Work Phone:** _____

Employee Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Employee Status: ☐ Active ☐ Retired ☐ COBRA ☐ Leave of Absence **Employee Date of Birth:** / /

PATIENT INFORMATION

Patient Name: _____ **Birth Date:** / /

Sex: ☐ Male ☐ Female **Relationship to Employee:** ☐ Self ☐ Spouse ☐ Child ☐ Other

FAMILY/OTHER COVERAGE INFORMATION

Complete only if claim is for a dependent and/or other vision coverage is in effect.

Is the patient covered under another employer group vision insurance plan? ☐ Yes ☐ No **Effective Date:** / /

Name of Covered Person _____ **Date of Birth:** / /

Name of Other Group Plan: _____ **Telephone #:** _____

Name and address of Insurance Company:

AUTHORIZATION FOR RELEASE & ASSIGNMENT OF BENEFITS

To all providers of vision services:

I authorize the release of information concerning health care advice, treatment or supplies provided to Benefit Administrative Systems, LLC. This information will be used to evaluate claims for benefits. This authorization is valid for the term of the policy or contract under which this claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature _____ Date _____

I authorize payment of vision care benefits to the doctor and/or dispenser.

Patient's or Authorized Person's Signature _____ Date _____

Provider Information

Date of Service _____

Charges for materials supplied

Frames	$_____
Lens for right eye	$_____
Lens for left eye	$_____
Other	$_____

Type of lenses supplied

	Left eye	Right Eye
Plain Glass	_____	_____
Single vision	_____	_____
Bifocal	_____	_____
Trifocal	_____	_____
Contact	_____	_____

Reason for purchase (please check)

a) Initial prescription _____

b) Prescription change _____

c) Loss or breakage _____

d) Other (please explain) _____

_____

Give reasons and specific item cost for "Other" in above area (e.g. hardening, tinting, varigray, oversize lenses, etc.)

If glasses tinted, what was tint?

Name of prescribing Optometrist or Ophthalmologist - if signed by Optician

I am a legally qualified ☐ Ophthalmologist ☐ Optometrist ☐ Optician

Signed _____ Date _____

Address _____ Telephone # _____