GROUP VISION CLAIM FORM



Vision Service Plan ATTN: Out of Network Provider Claims P.O. Box 997100 Sacramento, CA 95899-7100

PLEASE BE AS COMPLETE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM. ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

PARIA -	10 BF	СОМ	PLETE	DBY	INSUR	ED												
1. PATIENT'S NAME (Last, First, Middle)					2. PA	2. PATIENT'S BIRTHDATE						NT'S SEX □ F	4. RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other					
5. INSURED'S NAME (Last, First, Middle)							6. INSURED'S SOCIA				AL SECU	RITY NO.	7. 1	7. INSURED'S BIRTHDATE				
8. INSURED'S S	TREET ADD	RESS						9	9. NA	AME OF	EMPLO	/ER / GROUP	NUMBER					
10. CITY, STATE	E, ZIP CODE																	
11. IS PATIENT	COVERED	FOR VISIO	N CARE R	Y ANOTHI	FR PI AN?			12 N/	2MF	ΔΝΠ ΔΓ	DRESS	OF OTHER CA	ARRIFR					
☐ Yes								12.10		71110710	DILESS	or orner c	WWILK					
13. INSURED'S					14. RELAT	IONSHIP T				15. IN	5. INSURED'S BIRTHDATE 16. I			6. INSURED'S S	INSURED'S SSN / GROUP NUMBER			
17. THIS SECT	ION MUST	BE COM	PLETED V	VITH EAC	H CLAIM S	UBMISSI	ION ONL	Y IF THI	E CL	AIM IS I	OR A	DEPENDENT	CHILD AG	E 19 OR OVER				
Is patient	a full-time	student	? □ Yes	□ No. If	YES, Nam	e and Ad	ldress of	f School										
I HEREBY AUTH OF MY EXAM SUPPORT OF TI FOR CHARGES	ination o His Claim	R TREATN	MENT. I C LETE AND	ERTIFY TH	HAT THE A	ABOVE IN	IFORMAT	ION BY	ME	IN DC		AUTHORIZE DISPENSER.	PAYMEN	IT FOR ANY	BENEFITS TO THI	BELOW	NAMED	
Signature Of Insured										SIGNATURE OF INSURED				DATE				
	t is fraud	lulent to	fill out	this for	m with i	nformat	tion voi	ıı know	/ to	he fal	se or t	o knowina	ly omit f	acts which n	nay have a bea	ring		
	it is made	on	the ben	efits for	r which y	ou are	applyin	ig. Crin	nina	l and/	or civil	penalties	can resu	It from such	acts.	9		
PART B -	TO BE	COMI	PLETE	D BY I	DOCTO	R												
1. DOCTOR'S NAME (Last, First, Middle)															2. TITLE			
3. DOCTOR'S S	TREET ADD	PRESS										4. CITY, STAT	E, ZIP COD	DE	1			
5. PHONE			6.	WERE EY	EGLASSES	PRESCRIBI	ED? 💷 \	YES 📮	NO	7. H	AS CAT	ARACT SURG	ERY BEEN		INATION DATE PLE		MINATION	
()				WERE CC	NTACTS PI	RESCRIBE)? 💷 \	YES 📮	NO	PE	RFORM	ED? □ YES	□ NO	CHARGE	IN FEE COLUMN BELOW (BLOCK 12.)		
9. ASSIGNMEN	IT CANNOT	BE MADI	E WITHOU	T TAX I.D.	. NUMBER.	10.11	HEREBY (CERTIFY	THAT	ΓΙΗΑVE	PERFOR	RMED THE SEI	RVICES AS	INDICATED HEI	REON.			
Doctor's Tax	x I.D. #					DO	OCTOR'S	SIGNAT	URE .						DATE			
11. DIAGNOSIS	OR NATUF	RE OF OFF	ICE VISIT												12. EXAMINATION CHARGE	AMOU	NT 	
DA DT C	TO DE	COM	DI ETEI	D DV I	DOCTO	ND/DIG	DENIC	ED			CUEC	LIV ADDDO	DDIATE	DOY.	FRAME		1	
PART C - TO BE COMPLE				LILD BI DOCTOR			MFG.	<u>'LIX</u>			ZYL	METAL	METAL RIMLESS		CHARGE			
FRAME															LENS CHARGE		I	
LENSES	# OF LENSES	GLASS	PLASTIC		SV	BIF	TRI	PAL	SAFET		OTHE	R			OPTIONS		1	
LENS OPTIONS	OS	TINT	GRAD	DBL GRAD	COAT	UV400	FACET	PHOTO		OTHER					CHARGE CONTACT		l	
CONTACT LENSES	# OF LENSES	HCL	SCL	HGP	DISPOS- ABLE	SPH	BIF	TORIC	:	EW	TINT	NUMBER REPLACED	OTHER		CHARGE OTHER		<u> </u>	
DATE ORDERED				DATE	•	OTHE							SERVICES					
DISPENSING OFFIC	CE										Ph	HONE			SUBTOTAL			
ADDRESS				STREET CITY STATE ZIP									ZIP	SALES TAX (If Applicable)		1		
															- TOTAL CHARGES			
ASSIGNMENT CA							oer								AMOUNT PAID		1	
		01.111	5211	/ !!											BY PATIENT			
DISPENSER'S SIGN	NATURE							DA	TE									

Instructions

- A. Please print or type the insured portion of this form, in full, to assure prompt reimbursement. The insured should sign and date this form when work is completed.
- B. If two different providers are involved in providing the examination and the frame, lenses or contact lenses, then each provider should complete the appropriate section of the form.
- C. After the form has been fully completed it should be mailed to the address shown on front of form.

ABBREVIATIONS

FRAME MFGmanufacturer ZYLplastic COMBOcombination (Zyl/Metal)
LENSES
SVsingle vision
BIFbifocal
TRItrifocal
PALprogressive add lenses
LENS OPTIONS OSoversize GRADgradient
CONTACT LENSES
HCLhard contact lenses
SCLsoft contact lenses
HGPhard gas permeable
SPHspherical
BIFbifocal