

NORTHWEST BENEFIT NETWORK – VISION PLAN

ELIGIBILITY
AUTHORIZATION # _____

NAME OF GROUP **Highline School District**

PLAN # **HL**

EMPLOYEE INFORMATION

FIRST NAME	LAST NAME	DATE OF BIRTH	SPOUSE'S DATE OF BIRTH
STREET ADDRESS	CITY	ST	ZIP
SOCIAL SECURITY No.	NAME OF EMPLOYER	LOCAL UNION	

PATIENT INFORMATION

THIS CLAIM IS FOR	FIRST NAME	LAST NAME	DATE OF BIRTH	MALE <input type="checkbox"/>
SELF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FEMALE <input type="checkbox"/>
SPOUSE	IS THE PATIENT A FULL TIME STUDENT? Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, all information in the shaded box is REQUIRED	
DOMESTIC PARTNER	NAME OF SCHOOL CURRENTLY ATTENDING _____			
CHILD	LAST 4 QUARTERS ATTENDED	FALL Yr _____	WINTER Yr _____	SPRING Yr _____
STEP-CHILD	IF NOT ATTENDING SUMMER QUARTER, IS PATIENT ENROLLED FOR COMING FALL QUARTER? <input type="checkbox"/> Yes <input type="checkbox"/> No			
OTHER	IF NO, WHEN WAS LAST DAY ATTENDED?		MONTH _____	YEAR _____

OTHER COVERAGE INFORMATION (COMPLETION OF THIS SECTION IS REQUIRED)

DOES THE PATIENT HAVE OTHER VISION COVERAGE YES NO

IF YES, NAME OF PERSON WITH OTHER VISION COVERAGE _____ THEIR RELATIONSHIP TO THE PATIENT _____ DATE OF BIRTH _____ SOCIAL SECURITY No. _____

IF YES, NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THESE SERVICES _____ POLICY NUMBER _____

WAS VISION CARE REQUIRED BECAUSE OF AN INJURY? YES NO IF YES, ANSWER QUESTIONS BELOW

WAS INJURY CAUSED BY YOUR WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKERS COMPENSATION CARRIER? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS VISION REQUIRED AS A CONDITION OF YOUR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
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THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE TO FURNISH AND DISCLOSE ALL FACTS CONCERNING THIS CLAIM. I AGREE THAT, IF MY PLAN DOES NOT PROVIDE COVERAGE FOR THE EXPENSES INCURRED OR I AM NOT ELIGIBLE FOR BENEFITS, I WILL BE RESPONSIBLE FOR PAYMENT OF ALL CHARGES.

DATE _____ EMPLOYEE'S SIGNATURE _____

*** NOTE TO PROVIDERS *** **THE LOWER PORTION OF THIS CLAIM MUST BE COMPLETED BY THE ATTENDING PANEL PROVIDER**
*** PROVIDERS *** IF YOU ARE NOT AN NBN PANEL PROVIDER, PLEASE PROVIDE THE PATIENT WITH AN ITEMIZED BILL. YOU DO NOT NEED TO COMPLETE THIS CLAIM FORM.

NAME OF PROVIDER TO BE PAID	DEGREE(S)
OFFICE ADDRESS	TAX ID NUMBER
CITY	DATE SERVICES BEGAN
ST	DATE SERVICES COMPLETED
ZIP	

I hereby certify that I personally performed the professional services and have billed NBN no more than my usual and customary fee

Signature of Attending Provider _____ Date _____

EXAMINATION	EXAM FEE	LENS	LENS COST
COMPREHENSIVE <input type="checkbox"/>		SINGLE VISION <input type="checkbox"/>	
INTERMEDIATE <input type="checkbox"/>		BIFOCAL <input type="checkbox"/>	
LIMITED <input type="checkbox"/>		TRIFOCAL <input type="checkbox"/>	
		PROGRESSIVE <input type="checkbox"/>	
		OTHER <input type="checkbox"/>	
		<input type="checkbox"/> GLASS <input type="checkbox"/> PLASTIC	
CONTACT LENS	CONTACT EXAM FEE	CONTACT LENS	CONTACTS COST
EVALUATION/FITTING <input type="checkbox"/>		DISPOSABLE <input type="checkbox"/>	
		STANDARD <input type="checkbox"/>	
		GAS PERMEABLE / HARD <input type="checkbox"/>	
SUBNORMAL VISION AID		FRAMES	FRAMES COST
CONTACT LENS PRIOR AUTHORIZATION REQUIRED <input type="checkbox"/>		PATIENT'S FRAME <input type="checkbox"/> NEW FRAME <input type="checkbox"/>	
		IF NEW FRAME, BELOW IS REQUIRED	
		NAME _____	
		STYLE _____	
		MANUFACTURER _____	
	TAX RATE _____ %	TOTAL \$ _____	

PLEASE SEND COMPLETED AND SIGNED NBN COPY TO:
NORTHWEST BENEFITS NETWORK
 2323 EASTLAKE AVENUE EAST, SEATTLE, WA 98102
 (206) 726-3278 (800) 732-1123 WWW.NWADMIN.COM

PROVIDER, PLEASE RETAIN THE DOCTOR COPY FOR YOUR RECORDS.
 LAB COPY SHOULD ONLY BE SENT TO AN NBN APPROVED LAB.

NBN COPY LAB COPY PROVIDER COPY

DEPENDENT CHILD QUESTIONNAIRE

Please complete this form if the patient is 1) a natural child who does not reside with the employee, 2) stepchild, 3) a grandchild, or 4) a child for whom you have been appointed legal guardian.

1. Name of Employee _____ Soc. Sec. No. _____
2. Name of Dependent Child _____
 - a) Relationship to Employee _____
 - b) Date of Birth _____
3. Does the Employee contribute 50% or more of the child's yearly support? Yes No
4. Do you claim this child as an exemption on your income tax return? Yes No
5. Does the child reside in the Employee's home? Yes No
 - a) On what date did the child become a member of the Employee's household _____
6. Does the Employee have legal custody of the child? Yes No
7. Is there any other Vision coverage through Group Insurance which would cover the child? Yes No
 - a) Please provide the name and Social Security number of the Insured
 (name) _____ (SSN) _____
 - b) What is the name and address of the Insurance Company: (name) _____
 (address) _____

I hereby certify that the statements are correct and show the true circumstances of the person named.

 (Signature of Employee) _____ Date _____

AGREEMENT FOR ADDITIONAL MATERIALS, EXTRAS, OR SERVICES NOT COVERED BY THE PLAN

<u>ITEM</u>	<u>Amount</u>
Deductible _____	\$ _____
Frames – Excess Over Allowance _____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
<u>TOTAL</u>	\$ _____

I understand that I am financially responsible for the additional charges listed above.

 Patient's Signature _____ Date _____