CLAIM INSTRUCTIONS

- **Use this form to obtain reimbursement for services including assignment of payment to a provider of service.**
- **Part A to be completed by employee.**
- **Part B and C to be completed by provider.**
- **Submit the form to:**

National Vision Administrators®, LLC
PO Box 2187
Clifton, New Jersey 07015

If you have questions, please contact National Vision Administrators at: 1.800.905.4102.

BlueCrossVision℠

VISION CARE CLAIM FORM

NATIONAL VISION ADMINISTRATORS®, LLC
PO BOX 2187 / CLIFTON, NEW JERSEY 07015
1.800.905.4102

PRINT ALL INFORMATION

PART A—TO BE COMPLETED BY EMPLOYEE

1. EMPLOYEE'S NAME (Last, First, Middle)	2. EMPLOYEE'S ADDRESS (Number, Street, State, and ZIP Code)
3. EMPLOYEE'S SOCIAL SECURITY NUMBER	4. TELEPHONE NUMBER
5. EMPLOYER NAME	6. EMPLOYER ADDRESS (Number, Street, State, and ZIP Code)

7. PATIENT'S NAME (Last, First, Middle)	8. PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ Self ☐ Child ☐ Student ☐ Spouse ☐ Handicapped ☐ Other _____	9. PATIENT'S SEX ☐ Male ☐ Female	10. PATIENT'S DATE OF BIRTH

11. IS PATIENT COVERED FOR VISION CARE BY ANOTHER PLAN? ☐ NO ☐ YES	VISION PLAN NAME	GROUP NUMBER	NAME AND ADDRESS OF CARRIER

12.
Any person who knowingly and with intent to defraud any insurance company or other person; files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

13. SUBJECT TO THE TERMS AND CONDITIONS OF MY VISION BENEFITS PLAN, I HEREBY ASSIGN payment directly to the Doctor and/or Dispenser of the Vision Benefits otherwise payable to me. I understand that the plan will pay only the amount I am entitled to, and that any additional charges from the provider are my responsibility. Signature must be indicated on this claim form for assignment of payment to the Provider.

EMPLOYEE'S SIGNATURE _____ DATE _____

PART B—TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME (Last, First, Middle)	2. TAXPAYER IDENTIFICATION NUMBER	PROFESSIONAL SERVICES	AMOUNT
3. DOCTOR'S ADDRESS (Number, Street, City, State, and ZIP Code)		EYE EXAMINATION	
4. PHONE NUMBER (and Area Code)	5. TITLE ☐ M.D. ☐ D.O. ☐ O.D. / 6. EXAMINATION DATE(S) / 7. WAS CATARACT SURGERY PERFORMED? ☐ NO ☐ YES	CONTACT LENS EXAM (if any)	
8. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSES? ☐ NO ☐ YES	9. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? ☐ NO ☐ YES		
10. DIAGNOSTIC CODE(S)		AMOUNT PAID BY PATIENT	
11. INDICATE DIAGNOSIS OR NATURE OF DISEASE, INJURY, OR VISION DISORDER. CODE NUMBERS INDICATE PROCEDURE		12. VISUAL ACUITY CORRECTED TO:	

13.

DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
R.E.		●			
L.E.		●			
READING ADD		R.E.	+ ●	L.E.	+ ●

14. I hereby certify that I have performed the services as indicated heron.

DOCTOR'S SIGNATURE _____ DATE _____

PART C—TO BE COMPLETED BY DISPENSER

1. DISPENSER'S NAME (Last, First, Middle)	2. TAXPAYER IDENTIFICATION NUMBER
3. DISPENSER'S ADDRESS (Number, Street, City, State, and ZIP Code)	4. PHONE NUMBER (and Area Code)

5. PROFESSIONAL SERVICES:

	DATES(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS
1													
2													
3													
4													
5													
6													

6. PATIENT'S ACCOUNT NUMBER	7. TOTAL CHARGE $	8. AMOUNT PAID $	9. BALANCE DUE $

10. I hereby certify that I have performed the services as indicated hereon.

DISPENSER'S SIGNATURE _____ DATE _____