ADN ADMINISTRATORS

VISION CLAIM FORM
Eligibility Verification 1-888-236-1100
MAIL CLAIM FORM TO: ADN
PO BOX 610
SOUTHFIELD, MI 48037

EMPLOYER NAME:____

EMPLOYEE AND PATIENT PORTION

EMPLOYEE'S CONTRACT NUMBER/SSN | EMPLOYEE FIRST & LAST NAME | DATE OF BIRTH

EMPLOYEE'S ADDRESS

PATIENT NAME

PATIENT'S RELATIONSHIP TO EMPLOYEE
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

OTHER INSURANCE COVERAGE
IS PATIENT COVERED BY ANOTHER VISION PLAN? YES ☐ NO ☐ IF YES, PROVIDE NAME AND ADDRESS OF CARRIER

SOCIAL SECURITY NUMBER OF OTHER INSURED | NAME OF EMPLOYER

OTHER INSURED'S NAME | DATE OF BIRTH

IS THIS CONDITION CAUSED BY EMPLOYMENT? EXPLAIN

DOES CLAIM INVOLVE INJURY? YES ☐ NO ☐
WAS PATIENT INJURED AT WORK? YES ☐ NO ☐
DATE AND TIME OF INJURY_________________________________

I AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED DURING MY EXAM OR TREATMENT.

SIGNED (EMPLOYEE OR PATIENT) DATE

I AUTHORIZE PAYMENT OF BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER OF SERVICES DESCRIBED BELOW.
DO NOT SIGN IF YOU HAVE PAID UP FRONT FOR SERVICES

SIGNED (EMPLOYEE OR PATIENT) DATE

TO BE COMPLETED BY SERVICE PROVIDER OR ATTACH A DETAILED RECEIPT OR CLAIM

DATE(S) OF SERVICE	PROCEDURE CODE	DESCRIPTION	DIAGNOSIS	CHARGE

BILLING ENTITY AND ADDRESS

PHONE NUMBER -

TAX ID NUMBER -

PHYSICIAN'S LICENSE NUMBER -

SIGNATURE OF TREATING PHYSICIAN DATE