VISION CLAIM FORM

INSTRUCTIONS FOR COMPLETING FORM

- COMPLETE PART A. BEING SURE TO SIGN AND DATE THE FORM IN EACH OF THE APPROPRIATE SPACES.
- HAVE YOUR DOCTOR COMPLETE PART B OR ATTACH AN ITEMIZED BILL.
- HAVE PERSON FILLING PRESCRIPTION COMPLETE PART C.
- SEND CLAIM TO ADDRESS LISTED BELOW.

PART A — TO BE COMPLETED BY EMPLOYEE (ANSWER ALL QUESTIONS TO AVOID DELAY)

1. Name of Employee (Print last name, then first name)

2. Home Address

3. Claim is made for MYSELF ☐ SPOUSE ☐ CHILD ☐

Patient's name (if other than self) Patient Date of Birth

Patient's occupation

4. Is treatment the result of an accident? YES ☐ NO ☐

Date of Accident ____________ 20 ___, Time ________

Did accident happen at work? YES ☐ NO ☐

Describe how accident happened ________________

5. ☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Legally Sep.

6. Employee's Date of Birth

7. Employee's I.D. Number

8. A. Is your spouse/dependent employed? YES ☐ NO ☐
If yes, give:
B. Spouse name ________________
C. Employer name ________________
D. Employer Address ________________

9. Do you, your spouse or children have coverage under any vision plan other than with this plan?
YES ☐ NO ☐
A. If "Yes", give name of other insurance company(ies) and claim office address

B. Is this coverage provided on a group ☐ or individual ☐ basis?
C. Name and address of employer, union, school or organization through which this coverage is arranged.

D. Policy Number________________

10. Employment Status
Active ☐ Retired ☐ Laid Off ☐ Disability Leave ☐ Other ☐

11. EMPLOYER'S NAME
West Chester Area School District

12. GROUP NUMBER
6104

13. AUTHORIZATION TO PAY BENEFITS TO PROVIDER I hereby authorize payment directly to the undersigned Provider of the vision benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

14. I certify that the above statements and answers, including any accompanying bills and statements are true and complete to the best of my knowledge and belief. I authorize the release to and the use by TRUSTMARK HEALTH BENEFITS* of any medical or other information needed in processing this claim. A photocopy of this authorization shall be as valid as the original.

Date ________________ Signature of Employee ________________

FLEXIBLE SPENDING ACCOUNT – Automatic Reimbursement Election I elect automatic reimbursement from my Flexible Spending Account for expenses submitted that are not payable by the vision plan. I certify that 1) I have not been reimbursed by any other source for the enclosed charges and 2) I will not claim the charges as a deduction on my personal income tax return.

Signed ________________ Date ________________

Please mail Claim Statement to:
Trustmark Health Benefits*
P.O. Box 2920
Clinton, IA 52733-2920
Telephone: 1-800-223-3943

*Self-funded plans are administered by CoreSource, Inc. CoreSource, Inc. is a subsidiary of Trustmark Mutual Holding Company.

PART B EXAMINING OPHTHALMOLOGIST'S OR OPTOMETRIST'S STATEMENT

Diagnosis on Nature of Disease, Injury or Vision Disorder

____

Is the condition due to injury or sickness arising out of patient's employment?

YES ☐ NO ☐ **If yes, explain**

____

Report of Services (Or attach itemized bill)

Dates of Services	Services Rendered	Charges

Fee for

LENSES $__________ TOTAL CHARGES ► __________ BALANCE DUE

FRAMES $__________ AMOUNT PAID ► __________ __________

CONTACTS $__________

Did patient have glasses prior to this examination?

YES ☐ NO ☐ If yes, what type? ☐ Lenses in Frames ☐ Hard Contacts ☐ Soft Contacts

Does patient require a lens prescription change at this time?

YES ☐ NO ☐ If yes, why?

Are new frames required?

YES ☐ NO ☐

Materials prescribed (Check appropriate boxes and indicate number prescribed)

☐ Frames__________ ☐ Bifocal__________ ☐ Contact Lenses__________ ☐ Hard__________ ☐ Soft__________

☐ Single Vision __________ ☐ Trifocal __________ ☐ Other __________

If Tinted Lenses, Sunglasses and/or Safety Glasses prescribed, please explain

Date **Type or Print Full Name** **Degree**

Federal Tax ID or NPI #__________ __________ __________

Provider's Signature **Telephone**

All Others-Employer ID#__________ __________ __________

Must be furnished under Authority of Law

Street Address **City or Town** **State** **Zip Code**

PART C TO BE COMPLETED BY DISPENSER OF PRESCRIPTION – IF DIFFERENT FROM EXAMINING DOCTOR

(Or Attach Itemized Statement)

Date of Delivery **Fee For:**

LENSES $__________ FRAMES $__________ CONTACTS $__________

Type or Print Full Name

Federal Tax ID or NPI #__________ __________ __________

Dispenser's Signature **Telephone**

All Others-Employer ID#__________ __________ __________

Must be furnished under Authority of Law

Street Address **City or Town** **State** **Zip Code**