

# VISION CLAIM FORM

## PLEASE COMPLETE ONE CLAIM FORM PER PATIENT

<b>1. Complete all questions</b>  Check here if new address <input type="checkbox"/>	<b>A. Employer Information</b>	Name of Your Employer	Group number as shown on your ID Card			
	<b>B. Employee Information</b>	Last Name                      First Name                      MI	Employee's Social Security Number			
		Home Address	Employee's Birth Date			
		City                                      State                                      Zip	Month                      Day                      YR	Marital Status   Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/>		
<b>C. Patient Information</b>	Last Name                      First Name                      MI	Relationship to Employee				
	Patient's Birth Date	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>				
	Month                      Day                      YR	If over 19, is child a full-time student?   Yes <input type="checkbox"/> No <input type="checkbox"/>				
	Is Patient employed?   Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Name of Employer:	If yes, School attended:				
Does Employer offer Group Vision Plan?   Yes <input type="checkbox"/> No <input type="checkbox"/>		Does Employer offer Group Vision Plan?   Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>2. Complete the sections which apply to your claim</b>	<b>D. Complete if Patient is covered under any other vision plan</b>	Other Group Plan Name		Identification / Policy Number		
		Insurance Company Name and Address				
	City                                      State                                      Zip	<b>E. Complete if services are the result of an accident</b>		Is claim due to an accident?   Yes <input type="checkbox"/> No <input type="checkbox"/>		
Describe Accident		If "yes," where did the accident occur?		Date of accident		
		Month                      Day                      YR		Is this claim the result of a work-related illness or injury?   Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>3. Assignment of Benefits</b>	<b>F. Complete only if you wish payment to be made directly to the provider of service</b>	Name of Vision Service Provider				
		City                                      State                                      Zip		Provider's I.D. No.		
		Phone No. (      )		Employee's Signature Authorizing Assignment of Benefits		
		Date		Month                      Day                      YR		
<b>4. Must be signed and dated by the Employee</b>	<b>G. Read and complete authorization to release medical and insurance information</b>	<p>To any physician, medical practitioner, hospital, clinic or other medically-related facility or provider of medical services or supplies, and any employer, group policyholder, or contract holder or insurer, I authorize you to release to Select Benefit Administrators, Inc. or to its representatives any and all information you may have about the mental and physical history, condition and treatment, and insurance coverage for the Patient named in Section C above.</p> <p>I understand the information obtained by Select Benefit Administrators, Inc. will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by Select Benefit Administrators, Inc. to any person or organization EXCEPT to reinsuring companies, Group Policyholder, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required or as I may further authorize. For the purpose of disclosing information, I understand that this authorization is valid for a period of one year. I know that I may request a copy of this authorization. If this authorization is given in connection with a claim for health benefit, disability or life insurance benefits, I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original.</p>				
		Employee's Signature		Date		
		Month                      Day                      YR				

**PROVIDER MUST COMPLETE THE REVERSE SIDE.**

Please send the completed claim form and appropriate statements to:



P.O. Box 8339  
Des Moines, IA 50301-8339

**TO BE COMPLETED BY PROVIDER OF VISION SERVICES**

<b>PROVIDER OF SERVICE</b>				Charges	
Date of Service	Place of Service	Type of Service	Fully describe procedures, vision services, or supplies furnished for each date given.  (Explain unusual services or circumstances)		
Signature of Physician or Supplier			Accept Assignment Yes <input type="checkbox"/> No <input type="checkbox"/>	Total Charge	Balance Due
Signed		Date	Employer SS Number or	Physician's or Supplier's Name, Address, Zip Code, and Telephone No.	
Patient Account Number			Employer T.I.N. Number		
				I.D. No.	



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