Vision Claim Form – Eyewear

THIS CLAIM WILL NOT BE PROCESSED UNLESS THIS FORM IS FULLY COMPLETED AND A COPY OF THE PRESCRIPTION IS ENCLOSED

Employer Plan Services Inc
2180 North Loop West #400
Houston, TX 77018
713-932-8917

PART A – TO BE COMPLETED BY THE EMPLOYEE

1. EMPLOYEE'S NAME (LAST, FIRST, MIDDLE)	2. ADDRESS (NO. STREET, CITY, STATE AND ZIP CODE)

3. EMPLOYEE'S SOCIAL SECURITY NO.	4. EMPLOYEE'S LOCATION	5. PLAN NO	6. TELEPHONE NO	7. EMPLOYEE'S STATUS ☐ Active ☐ Retired ☐ Hourly ☐ Salaried

8. PATIENT'S NAME (LAST,FIRST,MIDDLE)	9. PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ CHILD ☐ SPOUSE ☐ HANDICAPPED ☐ OTHER ☐ STUDENT	10. PATIENT 'S SEX ☐ MALE ☐ FEMALE	11. PATIENT'S DATE OF BIRTH

12. EMPLOYER'S NAME AND ADDRESS

13. IS PATIENT COVERED FOR VISION CARE BY ANOTHER PLAN? YES ☐ NO ☐
IF YES VISION PLAN NAME GROUP NO. NAME, ADDRESS AND PHONE # OF CARRIER

PART B – TO BE COMPLETED BY DISPENSER

1. % OF REGULAR CHARGE ALLOWED AS A DISCOUNT _____%	2.DISPENSER'S NAME (LAST,FIRST,MIDDLE)	3.TAXPAYERS ID NO.

4. DISPENSER'S ADDRESS (NO.STREET, CITY STATE AND ZIP)	5.PHONE NO & AREA CODE	6.DISPENSER'S TITLE ☐ OPTHALMOLOGIST ☐ OPTOMETRIST ☐ OPTICIAN

7. TYPE OF LENSES DISPENSED ☐ SINGLE ☐ BIFOCAL ☐ TRIFOCAL ☐ LENTICULAR ☐ PROGRESSIVE ☐ CONTACTS ☐SUNGLASSES ☐ NONE ☐ OTHER	**8.DATE OF ORDER**	**DELIVERY**	9. MATERIALS SUPPLIED ☐ OVERSIZED ☐ GLASS ☐ PLASTIC ☐ PAIR ☐ ½ PAIR ☐ OTHER

Charges	Usual & Customary	Amount of Discount	Amount Billed to Plan	Amount Billed to Patient		Charges	Usual & Customary	Amount of Discount	Amount Billed to Plan	Amount Billed to Patient
Contact Lenses						Scratch Resistant Coating				
Contact Lens Supplies						Oversize Fee				
Lens (Single, Bi,Tri,Prog)						Tint				
Hi Index Lens						Anti-Reflective Coating				
Polycarb Lens						U-V Coating				
Transitional Lens						Service Agreements				
Sports Lens						Other-Describe				
Frames						Amt of Tax, If Any				
Totals						Totals				

PART C – TO BE COMPLETED BY THE EMPLOYEE AND THE DISPENSER

10. I hereby certify that I have dispensed the items indicated above.

11. I hereby authorize **payment directly to the Doctor and/or Dispenser** of the Vision Care Benefits otherwise payable to me.

DISPENSER'S SIGNATURE DATE EMPLOYEE'S SIGNATURE DATE

12. I hereby authorize any Insurance Company, Organization, Employer, Ophthalmologist, Optometrist, or Optician to release any information with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct.

EMPLOYEE'S SIGNATURE DATE DEPENDENT'S SIGNATURE (IF NOT A MINOR) DATE