Vision Claim Form – Exam

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

THIS CLAIM WILL NOT BE PROCESSED UNLESS THIS FORM IS FULLY COMPLETED

PART A – TO BE COMPLETED BY THE EMPLOYEE

1. EMPLOYEE'S NAME (LAST, FIRST, MIDDLE)

1. 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 DOCTOR

1. % OF REGULAR CHARGE ALLOWED AS A DISCOUNT __________%

2. DOCTOR'S NAME (LAST,FIRST,MIDDLE)

3. TAXPAYER'S ID NO.

4. DOCTOR'S ADDRESS (NO.STREET, CITY STATE AND ZIP)

5. PHONE NO. & AREA CODE

6. TITLE
☐ M.D.
☐ O.D. ☐ OTHER

7. **EXAMINATION DATE (S)**

8. HAS CATARACT SURGERY BEEN PERFORMED?
☐ YES ☐ NO

9. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSES?
☐ YES ☐ NO

10. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME?
☐ YES ☐ NO

11. DIAGNOSTIC AND PROCEDURE CODES:

12. INDICATE DIAGNOSIS OR NATURE OF DISEASE OR INJURY OR VISION DISORDER.

13. VISUAL ACUITY CORRECTED TO:

DOCTOR'S PRESCRIPTION					
Sphere		Cylinder	Axis	Prism	Base
R.E.					
L.E.					
READING ADD		R.E.	+ •	L.E.	+ •

CHARGES	USUAL & CUSTOMARY	AMT OF DISCOUNT	AMT BILLED TO PLAN	AMT BILLED TO PATIENT
BASIC EYE EXAM				
CONTACT LENS EXAM				
FITTING				
FOLLOW-UP				
TOTAL				

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

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

11. I hereby authorize payment directly to the Doctor of the Vision Care Benefits otherwise payable to me.

DOCTOR'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 is support of this claim is true and correct.

EMPLOYEE'S SIGNATURE DATE

DEPENDENT'S SIGNATURE (IF NOT MINOR) DATE