

GROUP VISION CLAIM FORM



Group Claim Office
P.O. Box 82520, Lincoln, NE 68501
Toll Free No.: (800) 255-4931

PLEASE BE AS COMPLETE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM. ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

PART A - TO BE COMPLETED BY INSURED

1. PATIENT'S NAME (Last, First, Middle)		2. PATIENT'S BIRTHDATE		3. PATIENT'S SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
5. INSURED'S NAME (Last, First, Middle)			6. INSURED'S SOCIAL SECURITY NO.		7. INSURED'S BIRTHDATE		
8. INSURED'S STREET ADDRESS				9. NAME OF EMPLOYER / GROUP NUMBER			
10. CITY, STATE, ZIP CODE							
11. IS PATIENT COVERED FOR VISION CARE BY ANOTHER PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please complete boxes 12 through 16.				12. NAME AND ADDRESS OF OTHER CARRIER			
13. INSURED'S NAME		14. RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		15. INSURED'S BIRTHDATE		16. INSURED'S SSN / GROUP NUMBER	

17. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER.

Is patient a full-time student? Yes No. If YES, Name and Address of School _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO AMERITAS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.

SIGNATURE OF INSURED _____ DATE _____

I HEREBY AUTHORIZE **PAYMENT** FOR ANY BENEFITS TO THE BELOW NAMED DOCTOR/DISPENSER.

SIGNATURE OF INSURED _____ DATE _____

It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and/or civil penalties can result from such acts.

PART B - TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME (Last, First, Middle)			2. TITLE <input type="checkbox"/> D.O. <input type="checkbox"/> M.D. <input type="checkbox"/> O.D.		
3. DOCTOR'S STREET ADDRESS			4. CITY, STATE, ZIP CODE		
5. PHONE	6. WERE EYEGLASSES PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE CONTACTS PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO		7. HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		8. EXAMINATION DATE PLEASE ENTER EXAMINATION CHARGE IN FEE COLUMN BELOW (BLOCK 12.)
9. ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Doctor's Tax I.D. # _____		10. I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON. DOCTOR'S SIGNATURE _____ DATE _____			

11. DIAGNOSIS OR NATURE OF OFFICE VISIT

PART C - TO BE COMPLETED BY DOCTOR/DISPENSER

CHECK APPROPRIATE BOX

FRAME	SIZE & MODEL					MFG.				ZYL	METAL	RIMLESS	COMBO
LENSES	# OF LENSES	GLASS	PLASTIC	SV	BIF	TRI	PAL	SAFETY	OTHER				
LENS OPTIONS	OS	TINT	GRAD	DBL GRAD	COAT	UV400	FACET	PHOTO CHROMIC	OTHER				
CONTACT LENSES	# OF LENSES	HCL	SCL	HGP	DISPOS-ABLE	SPH	BIF	TORIC	EW	TINT	NUMBER REPLACED	OTHER	
DATE ORDERED				DATE DISPENSED				OTHER SERVICES					

DISPENSING OFFICE _____ PHONE _____

ADDRESS _____ STREET _____ CITY _____ STATE _____ ZIP _____

ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Dispensers Tax I.D. Number _____

I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.

DISPENSER'S SIGNATURE _____ DATE _____

12. EXAMINATION CHARGE	AMOUNT
FRAME CHARGE	
LENS CHARGE	
OPTIONS CHARGE	
CONTACT CHARGE	
OTHER SERVICES	
SUBTOTAL	
SALES TAX (If Applicable)	
TOTAL CHARGES	
AMOUNT PAID BY PATIENT	

Instructions

- A. Please print or type the insured portion of this form, in full, to assure prompt reimbursement. The insured should sign and date this form when work is completed.
- B. If two different providers are involved in providing the examination and the frame, lenses or contact lenses, then each provider should complete the appropriate section of the form.
- C. After the form has been fully completed it should be mailed to the address shown on front of form.

ABBREVIATIONS

FRAME

MFGmanufacturer
ZYL.....plastic
COMBOcombination (Zyl/Metal)

LENSES

SVsingle vision
BIFbifocal
TRItrifocal
PAL.....progressive add lenses

LENS OPTIONS

OS.....oversize
GRADgradient

CONTACT LENSES

HCL.....hard contact lenses
SCLsoft contact lenses
HGPhard gas permeable
SPH.....spherical
BIFbifocal