



**VISION CARE
CLAIM FORM**

**CLAIMS ADMINISTRATOR
PO BOX 19108*RALEIGH, NC 27619**

PATIENT & INSURED (SUBSCRIBER) INFORMATION		
1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH / /	3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, zip code)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. INSURED'S ID
	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. INSURED'S GROUP NUMBER (OR GROUP NAME)
9. OTHER HEALTH INSURANCE COVERAGE	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	11. INSURED'S ADDRESS (Street, city, state, zip code)

PROFESSIONAL SERVICES

PROCEDURES/SUPPLIES	DATE OF SERVICE	CHARGES
12. Visual Analysis/Examination:		
13. Lenses: Single Vision		
14. Bifocal Vision		
15. Trifocal Vision		
16. Contact Lens: (after cataract surgery)		
17. Contact Lens: (other than after cataract surgery – note: one lens or two lenses)		
18. Frames:		
19. Diagnosis:		

OLD PRESCRIPTION				NEW PRESCRIPTION			
	Sphere	Cyl.	Axis		Sphere	Cyl.	Axis
R				R			
L				L			
Add R				Add R			
Add L				Add L			
Prism: _____				Prism: _____			

21. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____	23. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NUMBER. Tax I.D. number: _____
22. YOUR PATIENT ACCOUNT NUMBER	