

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 <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried	
8. PATIENT'S NAME (LAST, FIRST, MIDDLE)	9. PATIENT'S RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> HANDICAPPED <input type="checkbox"/> OTHER <input type="checkbox"/> STUDENT		10. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		11. PATIENT'S DATE OF BIRTH
12. EMPLOYER'S NAME AND ADDRESS					1053
13. IS PATIENT COVERED FOR VISION CARE BY ANOTHER PLAN? IF YES VISION PLAN NAME		YES <input type="checkbox"/> NO <input type="checkbox"/>		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 <input type="checkbox"/> M.D. <input type="checkbox"/> O.D. <input type="checkbox"/> OTHER	
7. EXAMINATION DATE (S)	8. HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	9. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO			
10. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? <input type="checkbox"/> YES <input type="checkbox"/> 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					CHARGES	USUAL & CUSTOMARY	AMT OF DISCOUNT	AMT BILLED TO PLAN	AMT BILLED TO PATIENT
Sphere	Cylinder	Axis	Prism	Base					
R.E.					BASIC EYE EXAM				
L.E.					CONTACT LENS EXAM				
READING ADD	R.E.	+ •	L.E.	+ •	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 _____