

# Vision Claim Form – Eyewear

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 AND A COPY OF THE PRESCRIPTION IS ENCLOSED**

**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 \_\_\_\_\_ 1053

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  
 OPHTHALMOLOGIST  
 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  1/2 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 \_\_\_\_\_