VISION CLAIM FORM

CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 365 DAYS FROM DATE OF SERVICE.

1. MEDICARE [ ] MEDICAID [ ] GROUP HEALTH PLAN [ ] OTHER [ ] (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE
   - MM
   - DD
   - YY

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT'S RELATIONSHIP TO INSURED
   - Self
   - Spouse
   - Child
   - Other

7. INSURED'S ADDRESS (No., Street)

8. PATIENT'S STATUS
   - Single
   - Married
   - Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. OTHER INSURED'S POLICY GROUP OR FECA NUMBER

11. OTHER INSURED'S DATE OF BIRTH
    - MM
    - DD
    - YY

12. OTHER INSURED'S SEX
    - M
    - F

13. OTHER INSURED'S EMPLOYER'S NAME OR SCHOOL NAME

14. INSURED'S NAME (Last Name, First Name, Middle Initial)

15. INSURED'S ADDRESS (No., Street)

16. INSURED'S STATUS
    - Single
    - Married
    - Other

17. EMPLOYER'S NAME OR SCHOOL NAME

18. INSURED'S POLICY GROUP OR FECA NUMBER

19. INSURED'S DATE OF BIRTH
    - MM
    - DD
    - YY

20. INSURED'S SEX
    - M
    - F

21. EMPLOYER'S NAME OR SCHOOL NAME

22. INSURANCE PLAN NAME OR PROGRAM NAME

23. IS THERE ANOTHER HEALTH BENEFIT PLAN?

24. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)

25. FEDERAL T AX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

28. TOT AL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH. #

SIGNED ____________________________ DATE __________