VISION CLAIM FORM

Regence
Regence BlueShield is an Independent Licen
of the Blue Cross and Blue Shield Associatio

1800 Ninth Avenue
P.O. Box 21065
Seattle, WA 98111-9145
http://www.wa.regence.com/boeing

1. EMPLOYEE / RETIREE INFORMATION

Name (First, Middle, Last)

Address

City State Zip

Home Telephone Number ( )

Boeing Telephone Number ( )

Alpha Prefix and Member ID (see Member card)

Date of Birth (Month/Day/Year) / /

2. PATIENT INFORMATION

Name (First, Middle, Last)

Address (If different)

City State Zip

Date of Birth (Month/Day/Year) / /

Do you have other group insurance? ❒ Yes ❒ No If yes, complete the following

Group Number

Employee/Retiree Name

Insurance Company Name and Address

3. EXAMINING PHYSICIAN OR OPTOMETRIST INFORMATION

Date of Service / /

Services Rendered

Refraction Included? ❒ Yes ❒ No

Charge

Physician's or Optometrist's Name, Address & Zip Code

Diagnosis

❒ Ophthalmologist ❒ Optometrist

Telephone Number

Enter the Taxpayer Identifying Number to be used for 1099 reporting purposes. You are required under authority of law to furnish your Taxpayer Identifying Number.

Signature of Physician or Optometrist

Date Signed

4. SUPPLIER INFORMATION (To be completed by dispenser of prescription)

All sections must be fully completed before this claim will be processed.

Lenses for ❒ One Eye ❒ Both Eyes

Date Ordered

Date Delivered

Glasses ❒ One Pair ❒ Two Pair

Special Features	Yes	No	(Extra Charge, if any)		Frames			
❒ Single Vision	$ _____	Plastic Lenses	❒	❒	$_____	❒	Existing	$_____
❒ Bifocal	$ _____	Oversize	❒	❒	$_____	❒	New	$_____
❒ Trifocal	$ _____	Tinting (of any kind)	❒	❒	$_____	❒	If new, why?	_____
❒ Lenticular	$ _____	Blended focal	❒	❒	$_____	❒	_____	
❒ _____	$ _____	Other_____	❒	❒	$_____		_____	

Aphakic? ❒ Yes ❒ No

TOTAL CHARGES (Including tax): $ _____

Contacts: Therapeutic? ❒ Yes ❒ No Aphakic? ❒ Yes ❒ No

Daily Wear Spherical Lenses	Daily Wear Toric	Flexible Wear
❒ Hard $ _____	❒ Soft $_____	❒ Soft $ _____
❒ Soft $ _____	❒ Gas Permeable $_____	❒ Gas Permeable $ _____
❒ Gas Permeable $ _____		

❒ Other _____ $ _____

Supplier's Name, Address & Zip Code

Physician/Supplier employer ID No.

Telephone Number

Enter the Taxpayer Identifying Number to be used for 1099 reporting purposes. You are required under authority of law to furnish your Taxpayer Identifying Number.

Signature of Physician or Optometrist

Date Signed

5. EMPLOYEE / RETIREE RELEASE INFORMATION

Employee/Retiree/Patient/Authorized Person's signature (read before signing). I authorize the release of any medical information necessary to process this claim from my provider of service or any insurance company involved in final benefit determination.

If allowed by the participating Blue Cross or Blue Shield Plan, I direct payment to be made to: ❒ The provider of service ❒ The employee/retiree

Signature_____ **Date**_____

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance.

INSTRUCTIONS

A. Most providers will bill directly for you and no claim form will be necessary. However, if you do incur expenses from a provider who will not bill the plan directly, you will need to complete sections 1, 2, and 5 of the claim form and then see **B** for instruction on sections 3 and 4.

B. Have your provider complete sections 3 and 4 (Physician or Supplier information) or attach completely itemized bills.

An itemized bill is one that includes:

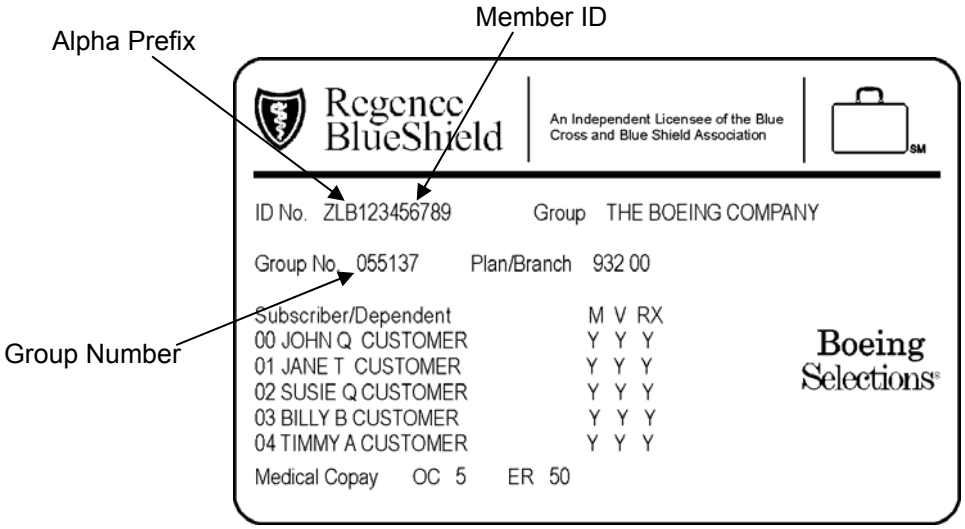
- Patient's name
- Member ID
- Alpha Prefix
- Date of service
- Type of services rendered
- Nature of the condition being treated
- Physician's or supplier's taxpayer identification number

If this information is missing, please write it in the appropriate area(s).

C. If services were rendered **in Western Washington**, please submit completed claim forms to:

Regence BlueShield
PO Box 21065
Seattle, WA 98111-3065

D. If services were rendered **outside of Western Washington**, please submit the claim form to the Blue Cross or Blue Shield plan in the area where services were rendered. If you need help locating the address of that plan, or questions about the claim form, please contact Regence BlueShield at 1 (800) 422-7713.



The card pictured above may not match your particular member card. This map is meant to be a guide to help you identify your alpha prefix, member and group numbers.