PLEASE ATTACH ITEMIZED RECEIPT HERE

VISION CLAIM FORM

P.O. Box 890500
Camp Hill, PA 17089-0500

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

Vision Claim Form Instructions

You only need to submit this claim form if you receive services from an out-of-network or non-participating doctor or optical supplier.

Complete **blocks 1-12** of the Vision Claim Form, **sign** the form, and **attach an itemized receipt** for the services you received.

1. **PATIENT'S NAME** - enter first, middle initial (if any), and last name. Do not use nicknames.
2. **PATIENT'S DATE OF BIRTH** - list date of birth by month, day, century, and year.
3. **INSURED'S NAME** - enter the first, middle initial, and last name of the person whose name appears on the Identification Card.
4. **PATIENT'S ADDRESS** - enter the address, including street, city, state, and ZIP code. Include your work and home telephone numbers.
5. **PATIENT'S SEX** - check the appropriate box.
6. **INSURED'S ID NO.** - enter the ID number exactly as it appears on the Identification Card. Be sure to include all letters and numbers.
7. **PATIENT'S RELATIONSHIP TO INSURED** - check the appropriate box.
8. **INSURED'S VISION GROUP NUMBER** - enter the vision Group Number exactly as it appears on the Identification Card.
9. **OTHER VISION INSURANCE COVERAGE** - enter the policyholder's name, the plan name and address, and policy or identification number. If there is no other insurance enter "NONE".
10. **WAS THE SERVICE REQUIRED AS THE RESULT OF AN ACCIDENT** - check the appropriate box.
11. **INSURED'S ADDRESS** - enter the address, including street, city, state, ZIP code of the policyholder -- the person with the vision insurance coverage, not his or her insurance company name.
12. **SIGN AND DATE THE FORM.**

Note: To obtain efficient claims processing and accurate payment for your services, please attach **an itemized receipt** to your claim form. Receipts indicating one charge for multiple services cannot be processed accurately without obtaining additional information.

Vision Claims Processing
P.O. Box 890500
Camp Hill, PA 17089-0500

If you have any questions, please contact our Customer Service Department at 1-800-541-2039 or your Benefits Administrator.

1. PATIENT'S NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH (MM/DD/CCYY) | |	3. INSURED'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, city, state, zip code)*	5. PATIENT'S SEX ❑ MALE ❑ FEMALE	6. INSURED'S ID NO. *(include any letters)*
Work Phone Number ( ) Home Phone Number ( )	7. PATIENT'S RELATIONSHIP TO INSURED ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER	8. INSURED'S VISION GROUP NO.
9. OTHER VISION COVERAGE *(Enter name of policyholder policyholder and plan name and address, and policy number)*	10. WAS THE SERVICE REQUIRED AS A RESULT OF AN ACCIDENT? ❑ YES ❑ NO	11. INSURED'S ADDRESS *(Street, city, state, zip code)*

12. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, we may use and disclose Protected Health Information for treatment, payment and health care operations as described in our Notice of Privacy Practices.

______________________________________ ________________
Your signature here verifies the information above is true and correct. Date