BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

450 Riverchase Parkway East • Birmingham, Alabama 35244-2858

VISION/HEARING CLAIM

☐ VISION CLAIM
☐ HEARING CLAIM

TYPE OR PRINT

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. Patient's Name *(First name, middle initial, last name)*

2. Patient's Date Of Birth
MM DD YYYY

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 I.D. Number *(Include any letters)*

7. Patient's Relationship To Insured
Self ☐ Spouse ☐ Child ☐ Other ☐

8. Insured's Group Number *(Or Group Name)*

9. Other Health Insurance Coverage
(Name of Policyholder, Plan Name and Address, and Policy or Medical Assistance Number. Attach a copy of your carrier benefit payment notice showing charges submitted and payments made.)

10. Was Condition Related To
A. Patient's Employment ☐ YES ☐ NO
B. An Auto Accident ☐ YES ☐ NO
C. An Accident ☐ YES ☐ NO

11. Insured's Address *(Street, city, state, ZIP code)*

12. A. DATE OF SERVICE FROM (MM DD YYYY)	TO (MM DD YYYY)	B. PLACE OF SERVICE	C. PROCEDURE CODE	D. TOTAL CHARGES	E. NO. OF SERVICES
CLAIM TOTAL:					

13. Diagnosis

16. Referring Doctor or Provider

17. Referring Physician UPIN Number

18. Signature of Physician or Supplier

Signed _____ Date _____

19. Make Payment To:
☐ PROVIDER ☐ PATIENT

14. DISTANCE

	SPHERE	CYLINDER	AXIS	PRISM
RIGHT				
LEFT				

The lens prescription must be included for reimbursement of lens purchase.

15. TYPE LENSE

☐ BIFOCAL ☐ TRIFOCAL ☐ PLANO
☐ GLASS LENS ☐ PLASTIC LENS ☐ CONTACT LENS

20. Physician's or Supplier's Name, Address & Zip Code

Telephone Number [ ] –

21. Provider Number	22. Tax ID Number