

Mailing Address:
P.O. Box 1250
Tuscaloosa, Alabama 35403



VISION CLAIM FORM

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

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 		3. PATIENT'S BIRTH DATE SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) 		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
6. PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street)
CITY STATE 	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY STATE
ZIP CODE TELEPHONE (Include area code) 	Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part Time Student <input type="checkbox"/>	ZIP CODE TELEPHONE (Including Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 		10. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER 		a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>
b. OTHER INSURED'S DATE OF BIRTH SEX M <input type="checkbox"/> F <input type="checkbox"/> MM DD YY		b. EMPLOYERS NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME 		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME 		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d
11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of benefits to the undersigned physician or supplier for services described below. SIGNED _____

COMMENTS

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

1. _____ 3. _____
2. _____ 4. _____

	24. A DATE(S) OF SERVICE			B. Place of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	I. ID QUAL.	J. RENDERING PROVIDER ID #
	From MM DD YY	To MM DD YY			CPT/HCPCS	MODIFIER					
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 	28. TOTAL CHARGE \$ _____	29. AMOUNT PAID \$ _____	30. BALANCE DUE \$ _____
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____	32. SERVICE FACILITY LOCATION INFORMATION A. _____ B. _____	33. BILLING PROVIDER INFO & PH. # () A. _____ B. _____
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P A T I E N T A N D I N S U R E D I N F O R M A T I O N P A T I E N T I N F O R M A T I O N P H Y S I C I A N O R S U P P L I E R I N F O R M A T I O N