



VISION CLAIM FORM

BlueCard® Program

BLUE CROSS AND BLUE SHIELD OFFICE USE ONLY

NOTE

A separate claim form must be completed for each patient and each provider. All information sections **must** be completed. Please check with your provider of care to see if he or she has already filed any of these charges for you.

SUBSCRIBER INFORMATION

1. Identification number: Enter the identification number and any alpha prefix as shown on your Blue Cross and Blue Shield card. (If you are age 65 or older, this number may not be the same as your Medicare number.)
2. Subscriber's home phone number: The area code and phone number.
3. Subscriber's name: Enter the subscriber's name as shown on your identification card.
4. Subscriber's address: The home address of the subscriber.

PATIENT INFORMATION

5. Patient's name: The patient's full legal name (not nickname) and "Jr." or "Sr." if applicable.
6. Patient's relationship to subscriber: Check the appropriate box to indicate the relationship of the patient to the subscriber.
7. Sex: The sex of the patient.
8. Date of birth: The date of birth of the patient. Provide month, day and year.