VISION/EYE CARE CLAIM FORM

CareFirst
From the CareFirst BlueCross BlueShield family of health care plans.

PATIENT AND SUBSCRIBER INFORMATION

1. PATIENT'S NAME *(First, Middle Initial, Last Name)*	**2. PATIENT'S DATE OF BIRTH**	**3. SUBSCRIBER'S NAME** (*First, Middle Initial, Last Name)*
4. PATIENT'S OTHER INSURANCE INFORMATION *IS PATIENT COVERED UNDER OTHER INSURANCE?* *YES* ❑ *NO* ❑ *IF YES, NAME OF INSURANCE CO.* *IS PATIENT COVERED UNDER MEDICARE? YES* ❑ *NO* ❑ *IF YES, PART A* ❑ *PART B* ❑ *NAME OF POLICY HOLDER (INCLUDING MEDICARE)* INSURANCE OR HIC NUMBER	**5. PATIENT'S SEX** *MALE* ❑ *FEMALE* ❑ **7. RELATIONSHIP TO SUBSCRIBER** *SELF* ❑ *SPOUSE* ❑ *CHILD* ❑ *OTHER* ❑ **9. WAS CONDITION DUE TO:** *WORK? YES* ❑ *NO* ❑ *AUTO ACCIDENT? YES* ❑ *NO* ❑ *ANOTHER PARTY AT FAULT? YES* ❑ *NO* ❑ *IF YES, ATTACH DETAILS*	**6. SUBSCRIBER'S ID NUMBER** **8. SUBSCRIBER'S GROUP NUMBER OR ENROLLMENT CODE** **10. SUBSCRIBER'S ADDRESS** **CHECK IF NEW ADDRESS** ❑ *STREET* *CITY* *STATE* *ZIP*

11. I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION REQUIRED TO REVIEW AND PROCESS THIS CLAIM. ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

SIGNATURE OF SUBSCRIBER OR SPOUSE **DAYTIME TELEPHONE NO. ( )** **DATE**

12. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS ***(SEE REVERSE)***

I, THE UNDERSIGNED, AUTHORIZE AND REQUEST CAREFIRST BLUECROSS BLUESHIELD TO MAKE PAYMENT FOR BENEFITS DUE HEREIN TO:

NAME OF PROVIDER	*PROVIDER'S TAX OR SOCIAL SECURITY NUMBER*	*SIGNATURE OF SUBSCRIBER OR SPOUSE*	*DATE*

PROVIDER INFORMATION: TYPE OR PRINT: ITEMS 13-36 MUST BE COMPLETED BY THE PROVIDER

13. ICD - 9 - CM DIAGNOSIS CODE(S) OR BRIEFLY DESCRIBE CONDITION	**14. DATE PRESCRIPTION LENS ORDERED BY PATIENT**	**15. DATE OF INJURY** *(Accident or Onset)*
16. WERE NEW LENSES PRESCRIBED? **YES** ❑ **NO** ❑	**17. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? IF YES, DATE OF ONSET** **YES** ❑ **NO** ❑	**18. FOR SERVICES RELATED TO HOSPITALIZATION, DATE HOSPITALIZED** **ADMITTED** **DISCHARGED**

19. LENSES: *Glass* ❑ *Plastic* ❑ *Other* ❑	**20. PATIENT RX:**	**SPHERICAL**		**CYLINDRICAL**		**AXIS**
	R:	**L:**	**R:**	**L:**	**R:**	**L:**
21. LENSES: *Executive* ❑ *Flattop* ❑ *Other* ❑	**22. WAS THIS RX FOR SUNGLASSES?**	**23. REFERRAL -** ***SEE ITEM 23 ON REVERSE***	☐ ***Exam resulted in referral*** ☐ ***Exam resulted from referral*** ☐ ***None of the above***			
24. WERE LENSES OVERSIZED? *YES* ❑ *NO* ❑	**26. LAST VISION EXAM DATE**	**27. CATARACT SURGERY DATE**	**28. PROVIDER SPECIALTY** *Physician* ❑ *OD* ❑ *Optician* ❑			
25. WERE LENSES TINTED? *None* ❑ *Photogray* ❑ *Other* ❑						

29. A DATES OF SERVICE *FIRST* *LAST*	B PLACE OF SERVICE	C PROCEDURE CODE	D SERVICES OR SUPPLIES PROVIDED	E CHARGES	F FREQ	G TYPE OF SERVICE
1.	30	92004	A comprehensive examination and evaluation with initiation of diagnostic and treatment program			9M0
2.	30	92002	An intermediate examination and evaluation with initiation of diagnostic and treatment program			9M0
3.	30	92081	Visual Field examination with or without refraction			9M0
4.	30	V2101	Half pair, single vision lens			9M0
5.	30	V2201	Half pair, bifocal lens			9M0
6.	30	V2301	Half pair, trifocal lens			9M0
7.	30	92396	Supply of permanent prosthesis for aphakia, half pair, contact lens			9M0
8.	30	92391	Supply of contact lenses, half pair, except prosthesis for aphakia			9M0
9.	30	V2020	Frames, purchase			9M0
10.	30	V2115	Lenticular lens, per lens			9M0
11.	30	92499	Not Otherwise Classified			9M0
12.						9M0

30. PROVIDER'S NAME	31. PROVIDER'S TAX OR SSN	32. PROVIDER'S TELEPHONE NO.	33. TOTAL CHARGE	34. OTHER INS. PD. AMT.

35. PROVIDER'S ADDRESS	36. SIGNATURE OF PROVIDER: I certify that the above services and/or supplies were provided by me or under my personal direction DATE

INSTRUCTIONS

THIS FORM IS USED TO SUBMIT A CLAIM FOR SERVICES UNDER YOUR HEALTH PLAN. TO AVOID HAVING YOUR CLAIM RETURNED:

- Prepare a SEPARATE CLAIM FORM for each family member.
- Complete ALL OF THE INFORMATION REQUESTED in items 1 through 11.
- Complete item 12 if you PREFER THAT BENEFITS BE PAID TO THE PROVIDER OF SERVICE. CareFirst BlueCross BlueShield reserves the right to make payment directly to the subscriber and to refuse to honor the assignment of any claim to any person or party.

Please complete Items 4, 6, and 8 as specified below:

Item 4: If you also have any other health insurance coverage for Vision/Eye Care, complete item 4.

Item 6: Indicate Identification Number as it appears on your Identification Card, or the subscriber's Social Security Number.

Item 8: Indicate the Group Number from your Identification Card.

PROVIDER INFORMATION

The provider is to complete items 13 through 36 as indicated. The following items are to be completed as specified below. If the provider does not complete the reverse side, a completely itemized bill must be attached.

Item 23: Complete with the name of the provider who referred the patient to you or the name of the provider to whom you referred the patient.

Item 29D: If the service or supply which you provided is preprinted under 29D, please complete the date of service, the place of service if appropriate, the charge and the frequency. If the service or supply which you provided is not printed under 29D, please complete the blank line under Item 29.

Item 29D.3: Visual field examination with diagnostic evaluation; with or without refraction; examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

Item 29F: Unless otherwise indicated by the procedural description, the frequency of supplies is important when billing for one or more lenses. Use this to indicate the number of lenses or the frequency of each specified code.

Item 36: If the claim form is being used in place of an itemized bill, the provider must sign and date the claim in item 36.

BEFORE SUBMITTING YOUR CLAIM, PLEASE BE SURE THAT:

1. The subscriber has completed items 1-11 and item 12, if applicable.
2. The provider has completed items 13-36 or a completely itemized bill is attached.
3. You have kept copies of the claim for your personal records, if needed.

Vision/Eye Care Program subscriber claims should be submitted to:

CareFirst BlueCross BlueShield
Mail Administrator
P. O. Box 14115
Lexington, KY 40512-4115