SELF INSURED PLANS, LLC

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EMPLOYER NAME

VISION CARE CLAIM FORM

PART A — TO BE COMPLETED BY EMPLOYEE

1	GROUP POLICY NO. COPY FROM YOUR I.D. CARD	EMPLOYER			BRANCH OR DIVISION
2	NAME OF EMPLOYEE	☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED	SEX ☐ M ☐ F	BIRTHDATE	SOCIAL SECURITY NO.
3	ADDRESS OF EMPLOYEE, NO. STREET	CITY	STATE	ZIP	
4	TELEPHONE NO.	DATE YOU LAST WORKED	HAS YOUR EMPLOYMENT BEEN TERMINATED? ☐ YES ☐ NO	IF YES, WHEN?	
5	IF MARRIED, YOUR SPOUSE'S FIRST NAME IS SPOUSE EMPLOYED ☐ YES ☐ NO	SPOUSE'S DATE OF BIRTH	NAME AND ADDRESS OF SPOUSE'S EMPLOYER		
6	COMPLETE LINES 6 & 7 FOR DEPENDENT CLAIMS ONLY	NAME OF DEPENDENT/ PATIENT	☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED	SEX ☐ M ☐ F	BIRTHDATE / RELATIONSHIP
7		EMPLOYER (IF ANY) OF DEPENDENT/PATIENT		ADDRESS OF DEPENDENT/PATIENT	
8	HAVE YOU (OR YOUR DEPENDENT) VISITED A DOCTOR OR TAKEN PRESCRIPTION MEDICINE FOR THIS CONDITION BEFORE DATES SHOWN BY YOUR DOCTOR ON THIS FORM? ☐ YES ☐ NO	IF YES, NAME AND ADDRESS OF DOCTOR		DATE OF TREATMENT	
9	DO YOU HAVE ANY FAMILY MEMBERS HAVE ANY OTHER BENEFIT PLAN FOR THE EXPENSES SUBMITTED? ☐ YES ☐ NO	IF YES (A) INSURANCE CO. (B) EMPLOYER (C) POLICY NO. OR I.D. NO.			
10	IS CONDITION DUE TO ACCIDENTAL INJURY? ☐ YES ☐ NO	IF YES WAS THE INJURY CAUSED BY THE ACT OR OMISSION OF A PERSON OTHER THAN YOURSELF? ☐ YES ☐ NO	PLACE OF ACCIDENT ☐ AUTO ☐ WORK ☐ HOME ☐ OTHER	DATE OF ACCIDENT	

AUTHORIZATION: I HEREBY AUTHORIZE RELEASE TO OR BY SELF INSURED PLANS LLC OF ANY HOSPITAL, MEDICAL, OR OTHER BENEFIT INFORMATION CONCERNING MYSELF OR ANY OF MY DEPENDENTS WHICH MAY BE REQUIRED TO PROCESS MY CLAIM A PHOTOCOPY OF THE AUTHORIZATION MY BE HONORED.

EMPLOYEE'S SIGNATURE

DATE SIGNED

HOW TO FILE YOUR CLAIM

IMPORTANT NOTICE TO EMPLOYEE — READ CAREFULLY

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claims containing any false, incomplete or misleading information may be subject to criminal penalties.

Have your doctor and optician complete Part B on the back of claim form and return it to you.

Attach an itemized bill for any charges not shown on the form. DO NOT SEND CANCELLED CHECKS, CASH REGISTER RECEIPTS OR LISTS PREPARED BY THE CLAIMANT. THE ACTUAL BILLS ARE NEEDED. If you wish to assign benefits please sign where indicated on the reverse side.

PART B

STATEMENT OF VISION CARE
Examination and Materials

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST

Patient's Name _____

Nature of disease, injury or vision disorder, if any _____

Did this disorder arise out of patient's employment? ☐ YES ☐ NO

IF YES, EXPLAIN _____

_____

SERVICES PROVIDED

Eye Examination, Including Refraction $ _____ Eye Examination Without Refraction $ _____

Other (describe) _____ $ _____

PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Add for Reading
Right					
Left					

Did patient have eyeglasses prior to date of your examination? ☐ YES ☐ NO

If Yes, is prescription for new lenses different from that of lenses being replaced? ☐ YES ☐ NO

DATES OF EXAMINATIONS _____ _____ _____ _____

_____

I am a legally qualified ☐ OPHTHALMOLOGIST ☐ OPTOMETRIST

SIGNED _____ DATE _____

NAME (Please Print) _____ TIN# _____

ADDRESS _____ PHONE _____

TO BE COMPLETED BY PROVIDER OF MATERIALS
An itemized bill for lenses and frames may be submitted in place of this statement

MATERIALS PROVIDED Lenses for ☐ One Eye ☐ Both Eyes

Single Vision $_____ Bifocal $_____ Trifocal $_____ Lenticular $_____ Sunglasses $_____ Other $_____

If contact lenses prescribed, give reason _____

_____

Frames $ _____ Are existing frames being used for new lenses? ☐ YES ☐ NO

Date of Purchase _____

I am a legally qualified ☐ OPHTHALMOLOGIST ☐ OPTOMETRIST ☐ OPTICIAN

*SIGNED _____ DATE _____

NAME (Please Print) _____ TIN# _____

ADDRESS _____ PHONE _____

*If examining doctor provides glasses, only one signature is necessary

PLEASE RETURN FORM TO PATIENT

OPTIONAL ASSIGNMENT OF BENEFITS APPLIES TO CHARGES OF

☐ DOCTOR

☐ OPTICAL CO.

(PLEASE INDICATE)

I hereby authorize SELF INSURED PLANS LLC to pay directly to the provider(s) of services I have indicated the benefits for their charges otherwise payable to me

_____

EMPLOYEE'S SIGNATURE DATE