

VISION BENEFITS CLAIM FORM

Please submit your billing along with this claim form to our Plan Administrator at: The Health Plan, 1110 Main Street, Wheeling, WV 26003 1.888.816.3096

Employer:									
PATIEN	T & INSURED (S	UBSCRIBER) II	NFORM	ATION					
1. Patient'	s Name (First, Middle	2. Patients Date of Birth			3. Insured's Name (First, Middle Initial, Last Name)				
4. Patient's Address (Street, City, State, Zip Code)				5. Patient's Gender Male Female			6. Insured's I.D. Number		
			7. Patie	nt's relationship	to insured	8. Insure	ed's Group Numbe	er (Or Group Name)	
Name	HEALTH INSURABCE Co of Policyholder and f ss and Policy or Medi er	Nas condition related to: A. Patient's employment B. An auto accident			11. Insured's Address (Street, City, State, Zip Code)				
and request payment of Medicare Champus benefits either to myself or to the party who accepts assignment below described below.							ersigned physicia	of Medical Benefits to n or supplier for services	
Signed Date									
Did visual	analysis indicate a ch	nange in prescription	n from the	immediately pre	eceding pre	escription	? Yes No		
Services								Charges	
Exam	Date of Service							\$	
Lenses	Date of Service							\$	
	Type of Lenses:	Single Bi	ifocal		Trifocal				
	Were Lenses:	Tinted Su	unglasses/S	Safety Glasses	Other				
Frames	Date of Service							\$	
Contacts	Date of Service							\$	
Please advise reason for contacts (severe corneal astigmatism, severe corneal scarring, or patient prefers contacts etc.)									
INDIVIDUA	AL PRACTIONERS-SS#						Total	\$	
ALL OTHERS-EMPLOYER IRS#						-	Amount Paid	\$	
Must be furnished under aut			thority of lo	hority of law			Balance Due \$		
Date Physician's Name		е				rure			
Physician's SSN# or EIN#		IPI#	- ?l#			Phone#			
Street Address		City/To	City/Town			Zip Code	/		