VISION CARE EXPENSE CLAIM FORM

EBA&M

18002 Cowan, Irvine, CA 92614

TO BE COMPLETED BY THE EMPLOYEE – ITEMIZED RECEIPT REQUIRED

1	NAME OF EMPLOYEE	○ SINGLE ○ MARRIED	SEX: ○ MALE ○ FEMALE	BIRTHDAY	PHONE #
2	ADDRESS OF EMPLOYEE: NUMBER – STREET - STATE - ZIP CODE				
3	SSN# / EMPLOYER / POLICY# / DATE EMPLOYED / HAS YOUR EMPLOYMENT TERMINATED ○ YES ○ NO				
4	NAME OF CLAIMANT	○ SINGLE ○ MARRIED	SEX: ○ MALE ○ FEMALE	BIRTHDAY	RELATIONSHIP

SECTION 5-7 ONLY NEEDS TO BE COMPLETED IF BENEFITS ARE BEING COORDINATED WITH SPOUSE'S PLAN

5	IF MARRIED, SPOUSE'S FIRST NAME SPOUSE'S SOCIAL SECURITY NUMBER IS SPOUSE EMPLOYED? ○ YES ○ NO	NAME AND ADDRESS OF SPOUSE'S EMPLOYER
6	DOES THE PERSON FOR WHOM THIS CLAIM IS BEING MADE HAVE ANY OTHER GROUP INSURANCE OR PRIVATE MEDICAL PLAN COVERAGE FOR VISION CARE EXPENSES? YES/NO	IF YES, PLEASE COMPLETE THE FOLLOWING: A. NAME OF EMPLOYER B. NAME OF INSURANCE COMPANY C. ADDRESS OF INSURANCE CO. D. POLICY NUMBER E. CERTIFICATE NUMBER F. UNION LOCAL NUMBER
7	I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. INSURED'S SIGNATURE: DATE:	

SECTION BELOW ONLY NEEDS TO BE COMPLETED IF PAYMENT IS MADE DIRECTLY TO THE PROVIDER

DATE OF SERVICE BEGAN

DATE SERVICE COMPLETED

IS THIS A REPLACEMENT? ○ YES ○ NO

IF "YES," PLEASE GIVE REASON FOR REPLACEMENT

PRINT OR TYPE DOCTOR'S OR PROVIDER'S NAME / DEGREE / TELEPHONE #

DOCTOR'S OR PROVIDER'S ADDRESS - CITY - STATE - ZIP CODE

INCLUDING TONOMETRY ○ YES ○ NO

INCLUDING REFRACTION ○ YES ○ NO

○ ONE ○ TWO	EXAMINATION	$
○ ONE ○ TWO	FRAMES	$
○ ONE ○ TWO	LENSES – SINGLE VISION	$
○ ONE ○ TWO	LENSES – BIFOCAL	$
○ ONE ○ TWO	LENSES –TRIFOCAL	$
○ ONE ○ TWO	LENSES – CONTACT	$
○ ONE ○ TWO	LENSES – LENTICULAR	$
	TOTAL CHARGES	$

DOCTOR'S OR PROVIDER'S SIGNATURE

MUST BE FURNISHED UNDER AUTHORITY OF LAW

INDIVIDUAL PRACTIONERS SS # ALL OTHERS – EMPLOYER I.D. #