VISION CARE EXPENSE CLAIM FORM

PO BOX 17179
Irvine, CA 92623

TO BE COMPLETED BY THE EMPLOYEE – ATTACH RECEIPT

1	NAME OF EMPLOYEE	○ SINGLE ○ MARRIED	SEX ○MALE ○FEMALE	BIRTHDAY	PHONE #
2	ADDRESS OF EMPLOYEE: NUMBER – STREET - STATE - ZIP CODE				
3	POLICY # SSN# EMPLOYER	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 COORDIANTED WITH SPOUSES 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	ASSIGNMENT: I AUTHORIZE BENEFIT PAYMENT DIRECTLY TO THE PROVIDER OF SERVICE. 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		INCLUDING TONOMETRY ○ YES ○ NO INCLUDING REFRACTION ○ YES ○ NO	
IS THIS A REPLACEMENT? ○ YES ○ NO		○ ONE ○ TWO	EXAMINATION $
IF "YES," PLEASE GIVE REASON FOR REPLACEMENT		○ ONE ○ TWO	FRAMES $
PRINT OR TYPE DOCTOR'S OR PROVIDER'S NAME	DEGREE TELEPHONE #	○ ONE ○ TWO	LENSES – SINGLE VISION $
DOCTOR'S OR PROVIDER'S ADDRESS - CITY - STATE - ZIP CODE		○ 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. #