

EYE CARE GROUP CLAIM FORM

Group Claim Office / P.O. Box 82520, Lincoln, NE 68501
Toll Free No.: 800-255-4931 / www.ameritasgroup.com



PLEASE BE AS COMPLETE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM.
ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

PART A - TO BE COMPLETED BY INSURED

1. PATIENT'S NAME (Last, First, Middle)		2. PATIENT'S BIRTHDATE		3. PATIENT'S SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
5. INSURED'S NAME (Last, First, Middle)			6. INSURED'S SOCIAL SECURITY NO.		7. INSURED'S BIRTHDATE		
8. INSURED'S STREET ADDRESS				9. NAME OF EMPLOYER / GROUP NUMBER			
10. CITY, STATE, ZIP CODE							
11. IS PATIENT COVERED FOR EYE CARE BY ANOTHER PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please complete boxes 12 through 16.				12. NAME AND ADDRESS OF OTHER CARRIER			
13. INSURED'S NAME		14. RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		15. INSURED'S BIRTHDATE		16. INSURED'S SSN / GROUP NUMBER	

17. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER.

Is patient a full-time student? Yes No. If YES, Name and Address of School _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO AMERITAS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.

SIGNATURE OF INSURED _____ DATE _____

I HEREBY AUTHORIZE **PAYMENT** FOR ANY BENEFITS TO THE BELOW NAMED DOCTOR/DISPENSER.

SIGNATURE OF INSURED _____ DATE _____

It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and/or civil penalties can result from such acts.

PART B - TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME (Last, First, Middle)			2. TITLE <input type="checkbox"/> D.O. <input type="checkbox"/> M.D. <input type="checkbox"/> O.D.		
3. DOCTOR'S STREET ADDRESS			4. CITY, STATE, ZIP CODE		
5. PHONE ()	6. WERE EYEGLASSES PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE CONTACTS PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO		7. HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		8. EXAMINATION DATE PLEASE ENTER EXAMINATION CHARGE IN FEE COLUMN BELOW (BLOCK 12.)
9. ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Doctor's Tax I.D. # _____		10. I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON. DOCTOR'S SIGNATURE _____ DATE _____			

11. DIAGNOSIS OR NATURE OF OFFICE VISIT		12. EXAMINATION CHARGE	AMOUNT

PART C - TO BE COMPLETED BY DOCTOR/DISPENSER

CHECK APPROPRIATE BOX

FRAME	SIZE & MODEL				MFG.				ZYL	METAL	RIMLESS	COMBO	FRAME CHARGE	
LENSES	# OF LENSES	GLASS	PLASTIC	SV	BIF	TRI	PAL	SAFETY	OTHER				LENS CHARGE	
LENS OPTIONS	OS	TINT	GRAD	DBL GRAD	COAT	UV400	FACET	PHOTO CHROMIC	OTHER				OPTIONS CHARGE	
CONTACT LENSES	# OF LENSES	HCL	SCL	HGP	DISPOS-ABLE	SPH	BIF	TORIC	EW	TINT	NUMBER REPLACED	OTHER	CONTACT CHARGE	
DATE ORDERED		DATE DISPENSED			OTHER SERVICES						OTHER SERVICES			
DISPENSING OFFICE										PHONE ()		SUBTOTAL		
ADDRESS		STREET			CITY			STATE		ZIP		SALES TAX (If Applicable)		
ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Dispensers Tax I.D. Number _____													TOTAL CHARGES	
I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.													AMOUNT PAID BY PATIENT	
DISPENSER'S SIGNATURE _____ DATE _____														

Instructions

- A. Please print or type the insured portion of this form, in full, to assure prompt reimbursement. The insured should sign and date this form when work is completed.
- B. If two different providers are involved in providing the examination and the frame, lenses or contact lenses, then each provider should complete the appropriate section of the form.
- C. After the form has been fully completed it should be mailed to the address shown on front of form.

ABBREVIATIONS

FRAME

MFGmanufacturer
ZYL.....plastic
COMBOcombination (Zyl/Metal)

LENSES

SVsingle vision
BIFbifocal
TRItrifocal
PAL.....progressive add lenses

LENS OPTIONS

OS.....oversize
GRADgradient

CONTACT LENSES

HCL.....hard contact lenses
SCLsoft contact lenses
HGPhard gas permeable
SPHspherical
BIFbifocal