

CLAIM FOR VISION CARE BENEFITS

MERITAIN HEALTH
Please submit this form to the address located on the back of your ID Card.

EMPLOYER _____

For ALL claims - this area must be filled out completely

EMPLOYEE	Employee's Name (Please Print Full Name)			Employee ID Number				
	Last	First	Middle Initial	Employee's Date of Birth				
	Address			Month	/	Day	/	Year
	City		State	Zip		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
<i>If this is a new address, contact your employer's personnel office to activate changes.</i>								

*If the patient is a dependent, please complete **all** of the following. If the patient is the employee, go directly to the area below the shaded box.*

PATIENT	Patient's name (if other than employee)			Patient's ID Number				
	Last	First	Middle Initial	Patient's Date of Birth				
				Month	/	Day	/	Year
				Relationship to employee		If child, is (s)he married?		
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Is Patient Covered by Another Employer Group Plan or Retirement Group Plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please furnish the following:								
Name of employer: _____								
Name and address of Insurance Company or Organization: _____								

RELEASE	Any person who, with intent to defraud or knowing that he/she is facilitating a fraud, submits an application for coverages or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Criminal and/or Civil penalties can result from such acts.							
	I hereby authorize payment of these benefits be sent directly to: <input type="checkbox"/> PROVIDER OF SERVICE <input type="checkbox"/> EMPLOYEE <i>(attach itemized bill or receipt)</i>							
	PATIENTS SIGNATURE <i>(Parent or Guardian if Claim is on a Minor)</i> _____				DATE _____			

THIS SECTION TO BE COMPLETED BY PROVIDER

EXAM	Indicate the nature of Disease, Injury or Vision Disorder:			Date of Examination:	Name of Provider performing services (please print)		
	Refraction? <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Address				
	Tonometry? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cataract Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	City _____ State _____ Zip _____				
	Examination Charge: \$ _____	Amount Paid by Employee: \$ _____	Provider's Social Security or Tax ID Number <i>required by law</i>				
	Signature of Provider _____	Degree/Title _____	Date _____				

LENSES	Date Ordered	Date Dispersed	<input type="checkbox"/> Pair <input type="checkbox"/> 1/2 Pair			FRAMES	Date Ordered	Date Dispersed	Parts <input type="checkbox"/> Complete <input type="checkbox"/> Partial					
	OD	Sphere	Cylinder	Axis	Prism		Add	FRAME CHARGE \$ _____						
	OS						Name of Provider performing services (please print)							
	Type Lens:					Charge								
	<input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular					_____								
	<input type="checkbox"/> Contact Lenses _____					_____								
	<input type="checkbox"/> Oversized Lenses _____					_____								
	<input type="checkbox"/> Sunglasses _____					_____								
	<input type="checkbox"/> Tint # _____					_____								
	<input type="checkbox"/> Photosensitive - i.e. Brown, Gray, etc. _____					_____								
<input type="checkbox"/> Other _____					_____									
Lens Mfr. _____					_____									
LENS CHARGE \$ _____					Total Charge: \$ _____					Amount Paid by Employee: \$ _____				

IMPORTANT: CLAIMS CANNOT BE PAID UNTIL THE CLAIM FORM IS PROPERLY COMPLETED AND RECEIVED.
Do not send this form through your employer. **ATTACH PROVIDER BILLING.**

If you require assistance in presenting this claim, call your Service Delivery Team at the number listed on your healthcare I.D. card.