

CLAIM INSTRUCTIONS

- Use this form to obtain reimbursement for services including assignment of payment to a provider of service.
- Part A to be completed by employee.
- Part B and C to be completed by provider.
- Submit the form to:

NATIONAL VISION ADMINISTRATORS, LLC
P.O. BOX 2187
CLIFTON, NEW JERSEY 07015

If you have any questions, please contact BlueCross Vision at 800.905.4102.

On behalf of Capital BlueCross, National Vision Administrators, LLC (NVA®) provides the network and assists in the administration of network management services for the BlueCross Vision benefits program. NVA is an independent company.

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VISION CARE CLAIM FORM

NATIONAL VISION ADMINISTRATORS, LLC
 P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
 800.905.4102

PRINT ALL INFORMATION

PART A—TO BE COMPLETED BY EMPLOYEE												
1. EMPLOYEE'S NAME (Last, First, Middle)					2. EMPLOYEE'S ADDRESS (Number, Street, State, and ZIP Code)							
3. EMPLOYEE'S SOCIAL SECURITY NUMBER					4. TELEPHONE NUMBER							
5. EMPLOYER NAME					6. EMPLOYER ADDRESS (Number, Street, State, and ZIP Code)							
7. PATIENT'S NAME (Last, First, Middle)			8. PATIENT'S RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Student <input type="checkbox"/> Spouse <input type="checkbox"/> Handicapped <input type="checkbox"/> Other _____			9. PATIENT'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		10. PATIENT'S DATE OF BIRTH				
11. IS PATIENT COVERED FOR VISION CARE BY ANOTHER PLAN? <input type="checkbox"/> NO <input type="checkbox"/> YES		VISION PLAN NAME			GROUP NUMBER		NAME AND ADDRESS OF CARRIER					
12. Any person who knowingly and with intent to defraud any insurance company or other person; files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.												
13. SUBJECT TO THE TERMS AND CONDITIONS OF MY VISION BENEFITS PLAN, I HEREBY ASSIGN payment directly to the Doctor and/or Dispenser of the Vision Benefits otherwise payable to me. I understand that the plan will pay only the amount I am entitled to, and that any additional charges from the provider are my responsibility. Signature must be indicated on this claim form for assignment of payment to the Provider.												
_____ EMPLOYEE'S SIGNATURE					_____ DATE							
PART B—TO BE COMPLETED BY DOCTOR												
1. DOCTOR'S NAME (Last, First, Middle)				2. TAXPAYER IDENTIFICATION NUMBER				PROFESSIONAL SERVICES	AMOUNT			
3. DOCTOR'S ADDRESS (Number, Street, City, State, and ZIP Code)								EYE EXAMINATION				
4. PHONE NUMBER (and Area Code)		5. TITLE <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> O.D.		6. EXAMINATION DATE(S)		7. WAS CATARACT SURGERY PERFORMED? <input type="checkbox"/> NO <input type="checkbox"/> YES		CONTACT LENS EXAM (if any)				
8. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSES? <input type="checkbox"/> NO <input type="checkbox"/> YES				9. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? <input type="checkbox"/> NO <input type="checkbox"/> YES								
10. DIAGNOSTIC CODE(S)								AMOUNT PAID BY PATIENT				
11. INDICATE DIAGNOSIS OR NATURE OF DISEASE, INJURY, OR VISION DISORDER. CODE NUMBERS INDICATE PROCEDURE								12. VISUAL ACUITY CORRECTED TO:				
13. DOCTOR'S PRESCRIPTION					14. I hereby certify that I have performed the services as indicated hereon.							
Sphere		Cylinder	Axis	Prism	Base							
R.E.		●										
L.E.		●										
READING ADD		R.E.	+ ●	L.E.	+ ●							
_____ DOCTOR'S SIGNATURE					_____ DATE							
PART C—TO BE COMPLETED BY DISPENSER												
1. DISPENSER'S NAME (Last, First, Middle)					2. TAXPAYER IDENTIFICATION NUMBER							
3. DISPENSER'S ADDRESS (Number, Street, City, State, and ZIP Code)							4. PHONE NUMBER (and Area Code)					
5. PROFESSIONAL SERVICES:												
DATES(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS
From		To										
MM	DD	YY	MM	DD	YY							
1												
2												
3												
4												
5												
6												
6. PATIENT'S ACCOUNT NUMBER								7. TOTAL CHARGE	8. AMOUNT PAID	9. BALANCE DUE		
								\$	\$	\$		
10. I hereby certify that I have performed the services as indicated hereon.												
_____ DISPENSER'S SIGNATURE					_____ DATE							