

CLAIM FOR VISION CARE EXPENSE

NON-PARTICIPATING PROVIDER



NATIONAL VISION ADMINISTRATORS
P.O. Box 2187 / Clifton, New Jersey 07015
800-905-4102

Member Please Complete This Section <i>(Print)</i>									
LAST NAME	FIRST	CARD MEMBER ID NO.							
STREET ADDRESS		COMPLETE IF CLAIM FOR DEPENDENT							
		FIRST NAME	DATE OF BIRTH	SEX	STATUS				
CITY		STATE	ZIP	SPONSOR NAME			MARITAL STATUS		
							<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED		
IMPORTANT, I CERTIFY THAT THE PATIENT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FOR THE BENEFITS AND THAT I HAVE RECEIVED THE SERVICES DESCRIBED. I ALSO CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN ON THE JOB INJURY OR COVERED UNDER ANOTHER VISION PROGRAM. I FURTHER AUTHORIZE THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITER, SPONSOR, POLICY HOLDER AND THE EMPLOYER.									
MEMBER SIGNATURE _____					DATE _____				
IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? <input type="checkbox"/> YES <input type="checkbox"/> NO 2) SAFETY GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO 3) CATARACT SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN SPACE PROVIDED.									
IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN SPACE PROVIDED.									

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST <i>(Print)</i>				
EXAMINER NAME	<input type="checkbox"/> MD <input type="checkbox"/> OD	TAX ID #	PATIENT NAME	DATE OF EXAM
STREET ADDRESS		CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO		
CITY	STATE	ZIP	DID PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.		DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES: CHANGES:		SERVICE CHARGE
SIGNATURE _____		DATE _____		AXIS _____ SPHERE OR CYLINDER _____ \$
I HAVE PRESCRIBED <input type="checkbox"/> SINGLE VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> APHAKIC <input type="checkbox"/> CONTACTS <input type="checkbox"/> HARD <input type="checkbox"/> SOFT <input type="checkbox"/> COSMETIC <input type="checkbox"/> MEDICALLY REQUIRED				

TO BE COMPLETED BY DISPENSER <i>(Print)</i>									
DISPENSER NAME		TAX ID#		PATIENT NAME				DATE OF SERVICE	
STREET ADDRESS				Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD
CITY		STATE	ZIP	RIGHT					
I HEREBY CERTIFY THAT I HAVE RENDERED SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.				LEFT					
				MATERIALS SUPPLIED		CHARGES		NVA USE	
SIGNATURE _____				DATE _____		<input type="checkbox"/> SINGLE VISION			
LENSES	U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE			<input type="checkbox"/> BIFOCAL					
	TRADE NAME		WIDTH	<input type="checkbox"/> PAIR <input type="checkbox"/> ONE	<input type="checkbox"/> CONTACTS <input type="checkbox"/> HARD <input type="checkbox"/> SOFT				
				<input type="checkbox"/> GLASS <input type="checkbox"/> PLASTIC		<input type="checkbox"/> TINT # _____ COLOR _____			
	MANUFACTURER			SIZE	MODEL OR STYLE	<input type="checkbox"/> OTHER _____			
FRAMES	FRAME NUMBER			<input type="checkbox"/> PLASTIC <input type="checkbox"/> COMBINATION <input type="checkbox"/> NEW PATIENTS		<input type="checkbox"/> METAL			
						TOTAL CHARGE			