



A National Vision and Dental Company

VISION BENEFITS CLAIM FORM

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

TO BE COMPLETED BY THE CARDHOLDER

1. PATIENT'S NAME (Last, First, Middle)		2. CARDHOLDER'S GROUP #		3. CARDHOLDER'S ID#	
4. PATIENT'S BIRTH DATE	5. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	6. RELATIONSHIP TO CARDHOLDER <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		7. CARDHOLDER'S NAME (Last, First, Middle)	
8. CARDHOLDER'S ADDRESS (No., Street, City, State and Zip Code)				9. HOME NUMBER () ()	WORK NUMBER () ()
10. NAME OF INSURANCE CARRIER	11. NAME OF EMPLOYER	12. CARDHOLDER'S STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> HOURLY <input type="checkbox"/> SALARIED		13. CARDHOLDER'S BIRTH DATE	
14. PATIENT IS COVERED FOR VISION CARE BY ANOTHER PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, PLEASE COMPLETE BOXES 15 THROUGH 19		
15. NAME AND ADDRESS OF THE OTHER CARRIER					
16. CARDHOLDER'S NAME	17. RELATIONSHIP TO CARDHOLDER <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	18. CARDHOLDER'S DATE OF BIRTH	19. CARDHOLDER'S S.S. #/GROUP#		
20. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO AVESIS THIRD PARTY ADMINISTRATORS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION PROVIDED 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 CARDHOLDER _____

DATE SIGNED _____

PLEASE CHECK ALL ITEMS BELOW THAT APPLY TO THE SERVICES RENDERED BY YOUR EYE CARE PROVIDER

DATE OF SERVICE _____

EXAM

CONTACT LENS FITTING/EXAM

CONTACT LENSES

EYEGLASS LENSES

SINGLE VISION

BIFOCAL

TRIFOCAL

PROGRESSIVE (NO LINE BIFOCAL)

OTHER _____

FRAME

PLEASE SUBMIT THIS FORM WITH YOUR ITEMIZED RECEIPT(S) TO THE FOLLOWING

Avesis Third Party Administrators, Inc.
 Vision Claims Department
 P.O. Box 7777
 Phoenix, AZ 85011-7777

Should you have any questions or require further assistance, please call the Avesis Service Center toll free at (800) 828-9341.