# CLAIM FOR VISION CARE EXPENSE

## FOR NON-PARTICIPATING PROVIDERS

**NATIONAL VISION ADMINISTRATORS**
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
800-672-7723

### TO BE COMPLETED BY EMPLOYEE (*Print*)

LAST NAME | FIRST | CARD MEMBER SOC SEC NUM

STREET ADDRESS | FIRST NAME | DATE OF BIRTH / / | GENDER: ☐ MALE ☐ FEMALE | STATUS: ☐ SPOUSE ☐ CHILD

CITY | STATE | ZIP CODE | SPONSOR NAME | MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

I HEREBY 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.

EMPLOYEE'S SIGNATURE ______________________ DATE ______________

IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? ☐ YES ☐ NO 2) SAFETY GLASSES? ☐ YES ☐ NO 3) CATARACT SURGERY? ☐ YES ☐ NO IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN THE SPACE PROVIDED.

IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? ☐ YES ☐ NO IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE SPACE PROVIDED.

### TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST (*Print*)

EXAMINER NAME ☐ MD ☐ 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 EYEGLASSES? ☐ YES ☐ NO

CITY | STATE | ZIP CODE | DOES PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? ☐ YES ☐ NO

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.
SIGNATURE ______________ DATE ______

DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? ☐ YES ☐ NO IF YES, CHANGES:
AXIS ________ SPHERE/CYLINDER ________ | SERVICE CHARGE $

I HAVE PRESCRIBED: ☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ APHAKIC CONTACTS: ☐ HARD ☐ SOFT ☐ COSMETIC ☐ MEDICALLY REQUIRED

### TO BE COMPLETED BY DISPENSER (*Print*)

DISPENSER NAME: ModernEYES Optical | TAX ID#: 84119182 | PATIENT NAME | DATE OF SERVICE

STREET ADDRESS: 1635 Manheim Pike

CITY: Lancaster | STATE: PA | ZIP CODE: 17601

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.

SIGNATURE ______________ DATE ______

| Rx | SPHERE | CYLINDER | AXIS | PRISM | ADD |
|---|---|---|---|---|---|
| RIGHT | | | | | |
| LEFT | | | | | |

| MATERIALS SUPPLIED | CHARGES | NVA USE |
|---|---|---|
| ☐ SINGLE VISION | | |
| ☐ BIFOCAL | | |
| ☐ TRIFOCAL | | |
| ☐ APHAKIC | | |
| ☐ CONTACTS ☐ HARD ☐ SOFT | | |
| ☐ TINT # ____ COLOR ____ | | |
| ☐ OTHER ________ | | |
| FRAME | | |
| TOTAL CHARGE | | |

LENSES:
U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE
TRADE NAME | WIDTH | ☐ PAIR ☐ ONE ☐ GLASS ☐ PLASTIC

FRAMES:
MANUFACTURER NAME | SIZE | MODEL OR STYLE
FRAME NUMBER | ☐ PLASTIC ☐ METAL ☐ COMBINATION | ☐ NEW ☐ PATIENT'S

# CLAIM INSTRUCTIONS

**EMPLOYEE:**

- Use this form to obtain reimbursement for services.
- Complete the employee section of the form.
- Sign and date the form after checking for completeness.
- Attach copy of itemized receipts.
- Submit the form to:

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187
CLIFTON, NEW JERSEY 07015
TOLL FREE 800-672-7723

If you have any questions, please contact NVA at 800-672-7723.