

VISION



CLAIM FORM

P.O. Box 900
Elyria, OH 44036
800-223-9941

www.CommerceBenefitsGroup.com



Commerce Benefits Group

EMPLOYEE'S NAME (Last) (First)		EMPLOYEE SOCIAL SECURITY NUMBER
EMPLOYEE <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED	OCCUPATIONAL ILLNESS OR INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	PATIENT'S NAME, IF CLAIM IS FOR DEPENDENT
EMPLOYER		
<i>EMPLOYEE: Complete the applicable items in Parts 1 & 2. Give the form to your Doctor to complete Parts 3 & 4. Return the completed form to the above address.</i>		
PART 2:		
ITEM 1: COMPLETE FOR ALL CLAIMS		
THIS CLAIM IS FOR MALE <input type="checkbox"/> EMPLOYEE FEMALE <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD		DATE OF BIRTH OF THIS PERSON
EMPLOYEE'S NAME		IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYEE'S ADDRESS (No. Street, City, State, Zip Code)		
GIVE NATURE OF ILLNESS OR INJURY		IF CLAIM IS DUE TO ACCIDENT, STATE WHEN, WHERE AND HOW IT OCCURRED
ARE YOU <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED	DO YOU HAVE MORE THAN ONE EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME AND ADDRESS OF OTHER EMPLOYER
ITEM 2: COMPLETE IF YOU ARE MARRIED		
NAME OF SPOUSE		SPOUSE'S SOCIAL SECURITY NUMBER
IS YOUR SPOUSE EMPLOYED (IF "YES" NAME AND ADDRESS OF SPOUSE'S EMPLOYER)		
DOES YOUR SPOUSE HAVE OTHER GROUP VISION COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF SPOUSE'S GROUP VISION BENEFIT CARRIER (OTHER THAN THIS PLAN)	
ITEM 3: COMPLETE IF CLAIM IS FOR YOUR DEPENDENT OTHER THAN SPOUSE		
NAME OF DEPENDENT		INDICATE IF DEPENDENT CHILD IS OVER AGE 19 <input type="checkbox"/>
IS THIS DEPENDENT EMPLOYED (IF "YES", NAME AND ADDRESS OF EMPLOYER) <input type="checkbox"/> YES <input type="checkbox"/> NO		
DOES DEPENDENT HAVE OTHER GROUP VISION COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF DEPENDENT'S GROUP VISION BENEFIT CARRIER	
ITEM 4: COMPLETE FOR ALL CLAIMS		
TO BE COMPLETED BY EMPLOYEE		
PATIENT'S NAME		
AUTHORIZATION TO PAY: I hereby authorize payment directly to the provider of the Vision Care Benefits, if any, otherwise payable to me for the services as described below but not to exceed the reasonable and customary charge for those services.		SIGNED (EMPLOYEE) DATE:
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the provider to release any information acquired in the course of my examination or treatment.		SIGNED (PATIENT, OR PARENT IF MINOR) DATE:

HEALTH CLAIM - VISION CARE

PART 3: TO BE COMPLETED BY DISPENSER OF PRESCRIPTION

DIAGNOSIS ON NATURE OF DISEASE, INJURY OR VISION DISORDER

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?

YES NO *If yes, explain*

DATE PURCHASED	SINGLE VISION		BIFOCAL LENS		TRIFOCAL		CONTACTS		LENTICULAR		FRAMES	Sales Tax
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left		
ACQUISITION COST												
DISPENSING FEE												
TOTAL												

PROVIDER
NAME _____

ADDRESS _____

TO MAKE PAYMENT, CLAIMS OFFICE NEEDS YOUR TAXPAYER
IDENTIFICATION NUMBER IN THIS BLOCK

PROVIDER SIGNATURE _____

PART 4: EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST STATEMENT

PROVIDER
NAME _____ DATE OF EXAM _____ AMOUNT _____

ADDRESS _____ TAXPAYER IDENTIFICATION NUMBER

PROVIDER SIGNATURE _____

COMMENTS:

Any person who, with intent to defraud or knowing that s/he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.