HIGHMARK West Virginia

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 7026
Wheeling, WV 26003

# VISION CARE INSURANCE CLAIM FORM

## Patient & Insured (Subscriber) information

| | | |
|---|---|---|
| 1. Patient's Name *(First name, middle initial, last name)* | 2. Patient's Date of Birth | 3. Insured's Name *(First name, middle initial, last name)* |
| 4. Patient's Address *(Street, city, state, ZIP Code)* | 5. Patient's Sex<br>Male ❑ Female ❑ | 6. Insured's ID No. |
| | 7. Patient's Relationship to Insured<br>Self ❑ Spouse ❑ Child ❑ Other ❑ | 8. Insured's Group No. *(or Group Name)* |
| 9. Other Health Insurance Coverage – *Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number* | 10. Was Condition Related to:<br>A. Patient's Employment:<br>Yes ❑ No ❑<br>B. An Auto Accident:<br>Yes ❑ No ❑ | 11. Insured's Address *(Street, city, state, ZIP code)* |
| 12. Patient's or Authorized Person's Signature<br>*I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or the party who accepts assignment below.*<br>*Signed* *Dated* | | 13. *I authorize payment of medical benefits to undersigned physician or supplier for service described below.*<br>*Signed (Insured or Authorized Person)* |

## Examining Physician or Optometrist's Information

1. What was the purpose of this examination? _____
2. Did exam include: Refraction: ❑ Yes ❑ No Tonometry? ❑ Yes ❑ No
3. Date of this examination _____ Date of last examination _____
4. Does patient require a prescription change at this time? ❑ Yes ❑ No
   Axis change _____degrees. Diopter, sphere or cylinder change_____
   Will lenses improve visual acuity by at least one line on standard chart? ❑ Yes ❑ No
5. Are any of these charges covered by any other insurance, governmental or workers' compensation law? ❑ Yes ❑ No
   If YES, please identify fully on the back of this form, giving name of other insurance company and name of group.
6. Charge for this examination $_____ Amount paid by insured $_____

## Supplier's Statement

1. The following Lenses and/or Frames were ordered on _____ (DATE) for the above patient as prescribed on _____ (DATE) by Doctor_____.
   Note: Lenses are not covered unless new prescription differs from the most recent one by an axis change of 20 degrees or .50 diopter sphere or cylinder change and the change must improve visual acuity by at least one line on the standard chart.

2. Materials Supplied

| Type of Lens | No. of Lens | Charge | Extra charge for Photosensitive or Anti-reflective |
|---|---|---|---|
| Single Vision | _____ | $_____ | $_____ |
| Bifocal | _____ | _____ | _____ |
| Trifocal | _____ | _____ | _____ |
| Lenticular | _____ | _____ | _____ |
| Contact | _____ | _____ | _____ |
| Oversize | _____ | _____ | _____ |
| Sunglasses | _____ | _____ | _____ |
| Tint No. | _____ | _____ | _____ |
| Other | _____ | _____ | _____ |
| | Total Lens Charge | $_____ | $_____ |
| | Frames Charge | $_____ | |

| | Sphere | Cylinder | Axis | Prism | Add |
|---|---|---|---|---|---|
| OD | | | | | |
| OS | | | | | |

3. Is there any other insurance or a mine Safety Glass program which covers these charges?
   ❑ Yes ❑ No
4. If YES, please describe on the back of this form giving name of insurance company and group.

| | | | | |
|---|---|---|---|---|
| 5. Signature of Physician or Supplier<br>Signed Date | 6. Pay Code Number | 7. Total Charge | 8. Amount Paid | 9. Balance Due |
| | 10. Your Social Security No. | 11. Physician's or Supplier's Name, Address, ZIP code and Telephone No. | | |
| 12. Your Patient's Account No. | 13. Your Employer ID No. | | | |