VISION CARE BENEFIT CLAIM FORM

SELF-FUNDED PLANS, INC.
1432 Hamilton Avenue
Cleveland, Ohio 44114-1146
(216) 566-1455 or
1-800-722-7374

HOW TO FILE A CLAIM

1. Complete the Employee's Statement below. A separate Employee Statement is required for each patient. To ensure prompt processing, answer every question.
2. Have your physician complete the Statement of Physician or Optometrist.
3. Have the provider of materials complete the Statement of Provider.
4. Mail completed form to:
   SELF-FUNDED PLANS, INC.
   1432 HAMILTON AVENUE
   CLEVELAND, OHIO 44114-1146

EMPLOYEE'S STATEMENT

NAME OF EMPLOYER | ACCOUNT NO.

EMPLOYEE'S NAME (Please print full name) | EMPLOYEE'S SOCIAL SEC. # | MARITAL STATUS ☐ Single ☐ Widowed ☐ Divorced ☐ Married ☐ Legally Separated

HOME ADDRESS
Street City State Zip Code

PATIENT'S NAME | ☐ Employee ☐ Spouse ☐ Child | PATIENT'S BIRTHDATE

IS SPOUSE EMPLOYED? Yes ☐ No ☐
If "Yes" give name, address and telephone no. of employer.
If "No" give name, location of last employer and date last worked.

If patient is a child 19 or over and in school, give full name and address of school.

IS PATIENT COVERED BY ANOTHER VISION PLAN?

Any other Benefit Plan, Group Insurance, Union Welfare Plan or other arrangement of coverage for individuals in a group?	☐ Yes	☐ No
Blue Cross, Blue Shield or any other prepayment arranged on a group basis?	☐ Yes	☐ No
Any other coverage provided by an employer or any federal, state, or other government agency?	☐ Yes	☐ No
No-fault automobile insurance as a result of injuries sustained in an automobile accident?	☐ Yes	☐ No

If "yes" furnish name and address of employer, union, insurance company or governmental agency, type of coverage, and policy number below.

WAS ILLNESS OR INJURY DUE IN ANY WAY TO PATIENT'S OCCUPATION, AUTO ACCIDENT OR ANY OTHER TYPE OF ACCIDENT?
If yes, circle appropriate answer and give details.

I hereby certify that the above statements are true, accurate and complete. I authorize any person or institution rendering care, or any person or organization (including my employer) in possession of information concerning insurance or other benefits covering me or my dependents, to furnish to, or receive from SELF-FUNDED PLANS, INC. or its authorized representative, full information regarding such care or other benefit information. A photocopy of this authorization shall be as valid as the original.

NAME OF PATIENT (Print) _____ SIGNATURE OF EMPLOYEE _____ DATE _____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:
I hereby authorize payment of benefits directly to the Provider signing the Statement of Physician or Optometrist or Statement of Provider.

Signed (Employee or Authorized Person) _____

V-501 4/01

STATEMENT OF PHYSICIAN OR OPTOMETRIST

NAME OF PATIENT

1. Indicate nature of disease, injury or vision disorder.

2. Date of examination

3. If Contact Lenses prescribed, indicate reason: ☐ Cataract Sugery ☐ Irregular Astigmatism ☐ Keratoconus ☐ Irregular Corneal Curvature ☐ Other

4. If Contact Lenses were dispensed for Keratoconus, Irregular Astigmatism or Irregular Corneal Curvature, was it confirmed by Keratometric readings? ☐ Yes ☐ No

5. Could visual acuity be corrected to 20/70 in the better eye by use of conventional lenses? ☐ Yes ☐ No

6. TO OPHTHAMOLOGIST ONLY: Was the patient referred to you for an examination of an unresolved visual problem by an optometrist who performed a vision examination within the last 60 days? ☐ Yes ☐ No

7. Comments

EXAMINATION

8. Physician's or Optometrist's Name, Address, Zip Code, Phone Number

Name (As it appears on IRS form W-9) ☐ Physician ☐ Optometrist

Number Street

City

State Zip Code

Phone

9. Taxpayer ID No. _____ (As it appears on IRS form W-9)

10. Total Exam Charge $ _____

11. SIGNATURE OF PHYSICIAN OR OPTOMETRIST DATE SIGNED

STATEMENT OF PROVIDER

FRAMES-LENSES

12. Check materials furnished and indicate separate charges (including taxes) where shown:

13. DATE OF SERVICE:

14.

	SPHERE	CYLINDER	AXIS	PRISM	ADD
O.D.					
O.S.					

15. Lens Mfr. Seg. Style/Width Trade Name

16. Comments

☐ Plastic Basic Lenses $ _____
☐ Glass Additives
☐ Single Vision ☐ Tint #( ) $ _____
☐ Bifocal ☐ Gradient $ _____
☐ Trifocal ☐ Photochromic $ _____
☐ Lenticular ☐ Oversized $ _____
☐ Contact ☐ Other _____
☐ ½ Pair _____ $ _____

17. Frame Mfr. _____ and Frame Name _____

18. Indicate Parts: ☐ Complete ☐ Partial ☐ Composition ☐ ZYL ☐ Metal ☐ ZYL Comb.

19. Dispenser's Name, Address, Zip Code & Phone No. (Complete Only if different from above)

Name (As it appears on IRS form W-9) ☐ Physician ☐ Optometrist ☐ Optician

Number Street

City State Zip

Phone

20. Taxpayer ID No. (As it appears on IRS form W-9)

21. Total Lens Charge $

22. Frame Charge $

23. Tax $

24. Total Charge $

25. SIGNATURE OF DISPENSER DATE SIGNED