

# vision Group Claim Form

Ameritas Life Insurance Corp.



Claim Office / P.O. Box 82520, Lincoln, NE 68501-2520 / Toll Free 800-255-4931 / Fax 402-467-7336 / Web ameritas.com

## Part 1: To be completed by Employee

1. Patient's full name (first, middle initial, last)	2. Patient birthdate (MM/DD/YY) / /	3. Relationship to employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	4. Sex <input type="checkbox"/> M <input type="checkbox"/> F
5. Employee's full name (first, middle initial, last)	6. Employee's identification number	Employee's birthdate (MM/DD/YY) / /	
7. Employee's mailing address (street address or P.O. Box, City, State, ZIP)		8. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER Is patient a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, name and address of school:	
Email address:		10. Group number	Division number
9. Employer (company) name and address		Certificate number	

### Questions 11 and 12 must be completed with each claim submission.

11. Is patient covered by another vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of other carrier	Policy number	Name and address of other employer:
12. Other employee/subscriber name		Employee/subscriber identification number	Date of birth (MM/DD/YY) / /
		Relationship to patient	
13. I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of treatment. I certify these statements to be true and complete to the best of my knowledge.		Check one box only: 14A. <input type="checkbox"/> Please send payment to me OR 14B. <input type="checkbox"/> Please pay provider below	
X Signature (patient, or parent if minor) _____ Date _____		X Signature (insured person) _____ Date _____	

## Part 2: To be completed by Attending Vision Provider.

**IMPORTANT:** Please attach an itemized receipt including provider's name and address, specific procedures and materials purchased. If this is attached, you will not need to complete Part 2.

15. Vision care provider name and address		For Yes answers to questions 17-19, enter a brief description and dates.	
		17. Is treatment result of occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		18. Is treatment result of auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Specialty	Phone number	19. Other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email	Fax number	20. This is a (please check one): <input type="checkbox"/> Statement of actual services <input type="checkbox"/> Pretreatment estimate	
16. Federal Tax ID Number <input type="checkbox"/> SSN <input type="checkbox"/> TIN	NPI (National Provider Identifier)	21. Is this for LASIK/PRK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
License #	22. Date of Service	Exam	Materials
23. Examination and Treatment Record Please include date of service, description of services, procedure code and fee.			
<b>Service</b>	<b>CPT Code</b>	<b>Fee</b>	<b>Lenses</b>
LASIK/ left eye _____	_____	\$ _____	Single _____
PRK right eye _____	_____	\$ _____	Bifocal _____
Exam _____	_____	\$ _____	Trifocal _____
Lens fitting _____	_____	\$ _____	Progressive _____
Refraction _____	_____	\$ _____	Lenticular _____
Other _____	_____	\$ _____	Contacts _____
Frames _____	_____	\$ _____	Other _____
24. Remarks			25. Total \$ _____

26. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.

27. Address where treatment was performed

X  
Signature (Provider) \_\_\_\_\_ Date \_\_\_\_\_