



A National Vision and Dental Company

# VISION BENEFITS CLAIM FORM

PLEASE BE AS THOROUGH AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS FORM. ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

## TO BE COMPLETED BY THE CARDHOLDER

1. PATIENT'S NAME (Last, First, Middle)		2. CARDHOLDER'S GROUP #		3. CARDHOLDER'S ID#	
4. PATIENT'S BIRTH DATE	5. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	6. RELATIONSHIP TO CARDHOLDER <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		7. CARDHOLDER'S NAME (Last, First, Middle)	
8. CARDHOLDER'S ADDRESS (No., Street, City, State and Zip Code)				9. HOME NUMBER (   ) (   )	WORK NUMBER (   ) (   )
10. NAME OF INSURANCE CARRIER	11. NAME OF EMPLOYER	12. CARDHOLDER'S STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> HOURLY <input type="checkbox"/> SALARIED		13. CARDHOLDER'S BIRTH DATE	
14. PATIENT IS COVERED FOR VISION CARE BY ANOTHER PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, PLEASE COMPLETE BOXES 15 THROUGH 19	15. NAME AND ADDRESS OF THE OTHER CARRIER	
16. CARDHOLDER'S NAME	17. RELATIONSHIP TO CARDHOLDER <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	18. CARDHOLDER'S DATE OF BIRTH	19. CARDHOLDER'S S.S. #/GROUP#		
20. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO AVESIS THIRD PARTY ADMINISTRATORS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION PROVIDED BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.					

SIGNATURE OF CARDHOLDER \_\_\_\_\_

DATE SIGNED \_\_\_\_\_

## PLEASE CHECK ALL ITEMS BELOW THAT APPLY TO THE SERVICES RENDERED BY YOUR EYE CARE PROVIDER

DATE OF SERVICE \_\_\_\_\_

EXAM

CONTACT LENS FITTING/EXAM

CONTACT LENSES

EYEGLASS LENSES

SINGLE VISION

BIFOCAL

TRIFOCAL

PROGRESSIVE (NO LINE BIFOCAL)

OTHER \_\_\_\_\_

FRAME

## PLEASE SUBMIT THIS FORM WITH YOUR ITEMIZED RECEIPT(S) TO THE FOLLOWING

Avesis Third Party Administrators, Inc.  
 Vision Claims Department  
 P.O. Box 7777  
 Phoenix, AZ 85011-7777

Should you have any questions or require further assistance, please call the Avesis Service Center toll free at (800) 828-9341.