

CLAIM INSTRUCTIONS

EMPLOYEE:

- Use this form to obtain reimbursement for services.
- Complete the employee section of the form.
- Sign and date the form after checking for completeness.
- Attach copy of itemized receipts.
- Submit the form to:

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187
CLIFTON, NEW JERSEY 07015
TOLL FREE 800-672-7723

If you have any questions, please contact NVA at 800-672-7723.

CLAIM FOR VISION CARE EXPENSE FOR NON-PARTICIPATING PROVIDERS



NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
800-672-7723

TO BE COMPLETED BY EMPLOYEE *(Print)*

LAST NAME		FIRST		CARD MEMBER								
STREET ADDRESS				FIRST NAME	DATE OF BIRTH		GENDER		STATUS			
					/ /		MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>		SPOUSE <input type="checkbox"/>		CHILD <input type="checkbox"/>
CITY		STATE		ZIP CODE		SPONSOR NAME			MARITAL STATUS			
									<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED			
I HEREBY CERTIFY THAT THE PATIENT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FOR THE BENEFITS AND THAT I HAVE RECEIVED THE SERVICES DESCRIBED. I ALSO CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN ON THE JOB INJURY OR COVERED UNDER ANOTHER VISION PROGRAM. I FURTHER AUTHORIZE THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITER, SPONSOR, POLICY HOLDER AND THE EMPLOYER.												
EMPLOYEE'S SIGNATURE _____										DATE _____		
IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? <input type="checkbox"/> YES <input type="checkbox"/> NO 2) SAFETY GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO 3) CATARACT SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN THE SPACE PROVIDED.												
IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? <input type="checkbox"/> YES <input type="checkbox"/> NO IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE SPACE PROVIDED.												

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST *(Print)*

EXAMINER NAME	<input type="checkbox"/> MD <input type="checkbox"/> OD	TAX ID#	PATIENT NAME	DATE OF EXAM
STREET ADDRESS			CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL EYEGGLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CITY	STATE	ZIP CODE	DOES PATIENT HAVE EYEGGLASSES PRIOR TO YOUR EXAMINATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.			DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CHANGES:	SERVICE CHARGE
SIGNATURE _____			DATE _____	AXIS _____ SPHERE/CYLINDER _____ \$ _____
I HAVE PRESCRIBED: <input type="checkbox"/> SINGLE VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> APHAKIC CONTACTS: <input type="checkbox"/> HARD <input type="checkbox"/> SOFT <input type="checkbox"/> COSMETIC <input type="checkbox"/> MEDICALLY REQUIRED				

TO BE COMPLETED BY DISPENSER *(Print)*

DISPENSER NAME		TAX ID#		PATIENT NAME			DATE OF SERVICE		
STREET ADDRESS				Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD
CITY				RIGHT					
STATE				LEFT					
ZIP CODE				MATERIALS SUPPLIED			CHARGES		NVA USE
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.				<input type="checkbox"/> SINGLE VISION					
SIGNATURE _____				<input type="checkbox"/> BIFOCAL					
DATE _____				<input type="checkbox"/> TRIFOCAL					
L E N S E S	U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE			<input type="checkbox"/> APHAKIC					
	TRADE NAME	WIDTH	<input type="checkbox"/> PAIR <input type="checkbox"/> ONE <input type="checkbox"/> GLASS <input type="checkbox"/> PLASTIC	<input type="checkbox"/> CONTACTS					
F R A M E S	MANUFACTURER NAME			<input type="checkbox"/> HARD <input type="checkbox"/> SOFT					
	SIZE			<input type="checkbox"/> TINT # _____ COLOR _____					
	MODEL OR STYLE			<input type="checkbox"/> OTHER _____					
FRAME NUMBER				<input type="checkbox"/> PLASTIC <input type="checkbox"/> METAL <input type="checkbox"/> NEW <input type="checkbox"/> COMBINATION <input type="checkbox"/> PATIENT'S			FRAME		
				TOTAL CHARGE					