HealthSCOPE BENEFITS

VISION CARE CLAIM FORM

Return completed form to:
HealthSCOPE Benefits, Inc.
P.O. Box 99005
Lubbock, TX 79490-9005

Filing Instructions

1. In all cases, complete Part I "Employee's Statement."
2. If you wish payment made directly to the provider of service, complete the "Authorization to Pay Benefits," item 15.
3. Complete the "Authorization to Release Information," item 16.
4. Have attending physician, optometrist and/or optician complete the "Attending Physician's Statement" Part II and the "Provider of Materials Statement" Part III or attach the itemized billing statement from the Provider.
5. Send Completed claim form and all related bills to the address at the top of this form.

PART I EMPLOYEE'S STATEMENT

1. Name of Employee	2. SSN/Alternate ID	3. Date of Birth	4. Sex

5. Home Address	6. Plant Location

City	State	Zip	7. Occupation

8. Marital Status	Custody of Children	9. Name of Spouse	10. Spouse's Social Security No.	Date of Birth
☐ Single ☐ Married ☐ Divorced ☐ Widow(er)	☐ Yes ☐ No			

11. Is spouse employed?	If yes, Name, Address and Phone Number of Employer
☐ Yes ☐ No	

12. If Claim is for Dependent: Name of Patient	Date of Birth	Sex	Relationship to Employee
		☐ M ☐ F	

13. Are the benefits under this plan provided by any other Employer, Union, Student, Association Group Plan, or Governmental Program applicable to this claim?
☐ Yes ☐ No

IF YES, INSERT NAME AND ADDRESS OF OTHER GROUP POLICYHOLDER AND CARRIER PROVIDING BENEFITS

Name of Group Policyholder	Policy Number

Address of Group Policyholder

Name of Carrier Providing Benefits

Address of Carrier

14. Employee's Signature	Date Form Completed

15. **AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to the physician, optometrist or optician of the vision care benefits otherwise payable to me for services described but not to exceed the reasonable and customary charge for those services.**
Employee's Signature _____ Date _____

16. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the consulted physician, optometrist or optician to release any information acquired in the course of my examination or treatment.
Patient's or Parent's Signature if Minor _____ Date _____

PART II ATTENDING PHYSICIAN'S STATEMENT

17. Patient's Name | Age | 18. Date of Examination

19. Nature of disease, injury or vision disorder, if any

20. Did this disorder arise as a result of patient's employment?

☐ Yes ☐ No

21. PROCEDURES FEES

☐ Eye Refraction $_____

☐ Tonometry $_____

☐ Other $_____

22. MATERIALS PRESCRIBED

☐ Frames ☐ Lenticular Lenses

☐ Single Vision Lenses ☐ Contact Lenses

☐ Bifocal Lenses ☐ Other (specify)

☐ Trifocal Lenses _____

23. If Contact Lenses prescribed, give reason

24. What is visual acuity correctable with conventional lenses? Right Eye Left Eye

25. Did patient have eyeglasses prior to date of your examination?

☐ Yes ☐ No

26. If yes, is prescription for new lenses different from that of lenses being replaced? ☐ Yes ☐ No

27. PREVIOUS RX (If Applicable)

	Sphere	Cylinder	Axis	Prism	Add
Right Eye					
Left Eye					

28. NEW RX

	Sphere	Cylinder	Axis	Prism	Add
Right Eye					
Left Eye					

29. I am a legally qualified

☐ Ophthalmologist ☐ Optometrist

30. Taxpayer I.D. Number

THIS IS REQUIRED UNDER SECTION 6109 I.R.S. CODE AND APPLICABLE REGULATIONS THERETO.

31. Name Telephone

Address

32. Signature Date Signed

PART III PROVIDER OF MATERIAL'S STATEMENT

33. MATERIALS PROVIDED 34. Date of Delivery

☐ Frames $_____

☐ Single Vision Lenses $_____

☐ Bifocal Lenses $_____

☐ Trifocal Lenses $_____

☐ Lenticular Lenses $_____

☐ Contact Lenses $_____

☐ Other (specify) $_____

_____

35. I am a legally qualified

☐ Ophthalmologist ☐ Optometrist ☐ Optician

36. Taxpayer I.D. Number

THIS IS REQUIRED UNDER SECTION 6109 I.R.S. CODE AND APPLICABLE REGULATIONS THERETO.

37. Name Telephone

Address

38. Signature Date Signed

IF EXAMINING DOCTOR PROVIDES GLASSES, ONLY ONE SIGNATURE IS NECESSARY.