HealthSCOPE BENEFITS

VISION CARE CLAIM FORM

Mail Completed Claim Forms to: The Address on the back of your ID Card

PART I — PATIENT & MEMBER INFORMATION
(To be completed by member) (Please print or type)

1. PATIENT'S NAME (first name, middle initial, last name)

2. Patient's Relationship to member
Self Spouse Child Other

3. Patient's Date of Birth Age

4. Patient's Sex:
Male ☐
Female ☐

5. MEMBER'S NAME (first name, middle initial, last name)

6. Is patient a full-time student 19 years of age or over?
No ☐ Yes ☐

7. Name of School

Patient Marital Status:
Single ☐
Married ☐

8. MEMBER'S STREET ADDRESS
☐ Check here if new address

9. Member's Identification No. (Shown on your ID card)

10. CITY STATE ZIP

11. EMPLOYER./GROUP NAME

12. Do you or your spouse have other medical/vision coverage?
No ☐ ☐ Yes

If YES, please attach the "Explanation of Benefits" form showing the action taken by the other insurance company and complete the following:

Member's Name: _____
Member's Date of Birth: _____
Name of Other Benefits Administrator: _____
Location of Other Benefits Administrator: _____

Member's Employer: _____
Contract/Social Security No: _____

13. GROUP NO.

14. Is treatment due to an accident? No ☐ Yes ☐
If YES, give date of accident _____
Give brief description, when, where & how?

15. Member of Authorized Person's Signature

A. I authorize release to HealthSCOPE Benefits, any and all information pertaining to this claim. I certify that the information provided is true and complete.

_____
Member of Authorized Person's Signature (Date)

See instructions "NOTE" on back.

B. I certify that I paid the provider's charge in full and would like HealthSCOPE Benefits to issue payment to me. Check one box only ☐

I authorize HealthSCOPE Benefits to issue payment to the provider indicated on this claim. ☐

_____
Member or Authorized Person's Signature (Date)

PART II—TO BE COMPLETED BY PROVIDER OF SERVICES

Date of Service	Description of Services Or Supplies	Single OD	Vision OS	Bifocal OD	Bifocal OS	Trifocal OD	Trifocal OS	Lenticular OD	Lenticular OS	Contacts OD	Contacts OS	CHARGES
	Please Check Type of Lens Dispensed →											
	FRAME											
	EXAM											

DIAGNOSIS:

REFRACTION RX:

Total Charge

Provider's Name, Address, Zip & Telephone No.

Additional Comments:

I certify that these services have been performed and that supplied have been dispensed.

Signature of Provider Date

Federal Tax ID No.

Suffix

For Carrier Use Only:

CLAIM FILING INSTRUCTIONS

MEMBER:

1. Complete all items in Part I.
2. After you complete Part I, give this form to your provider to complete Part II.
3. Payment will automatically be issued to the provider if they are a HealthSCOPE Benefits Provider. If you have paid the bill in full, check the box in 15B and HealthSCOPE Benefits will issue the payment to you instead.
4. If you have any questions about filing a claim, please call the Customer Care number on your ID card.
5. Submit the completed claim form and itemized bill to the address listed on the ID card.

CLEAN CLAIM

A "clean claim" means a completed vision claim form and an itemized bill. If the provider doesn't complete this claim form, a clean claim should include the following:

- The provider's name and tax ID number;
- The date of service and the procedure codes with the provider's billed charge;
- The name of the your employer;
- The policy number and member ID on the ID card;
- The employee's name and home address;
- The patient's date of birth.

A clean claim does not include a claim with missing information or claims for coordination of benefits.

TIMELY FILING

Timely Filing Limits can be found in your SPD under the section titled "When Health Claims Must Be Filed". You can also contact the Customer Care team at the number listed on your ID card for help to find out your plan's timely filing requirement. The SPD and the Customer Care team number can also be found on the website at www.healthscopebenefits.com.