

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"/>		SPOUSE <input type="checkbox"/>		FEMALE <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				STATE		ZIP CODE		RIGHT		LEFT					
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.				MATERIALS SUPPLIED				CHARGES				NVA USE			
SIGNATURE _____				DATE _____				<input type="checkbox"/> SINGLE VISION							
U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE				<input type="checkbox"/> BIFOCAL											
TRADE NAME WIDTH <input type="checkbox"/> PAIR <input type="checkbox"/> ONE				<input type="checkbox"/> TRIFOCAL											
				<input type="checkbox"/> APHAKIC											
				<input type="checkbox"/> CONTACTS											
				<input type="checkbox"/> HARD <input type="checkbox"/> SOFT											
MANUFACTURER NAME SIZE MODEL OR STYLE				<input type="checkbox"/> TINT # _____ COLOR _____											
				<input type="checkbox"/> OTHER _____											
FRAME NUMBER <input type="checkbox"/> PLASTIC <input type="checkbox"/> METAL <input type="checkbox"/> NEW				FRAME											
				<input type="checkbox"/> COMBINATION <input type="checkbox"/> PATIENT'S											
				TOTAL CHARGE											