CLAIM INSTRUCTIONS

- **Use this form to obtain reimbursement for services including assignment of payment to a Provider of service**
- **Part A to be completed by Employee**
- **Part B & C to be completed by Provider**
- **Submit the form to:**

National Vision Administrators
P.O. Box 2187
Clifton, New Jersey 07015

If you have questions, please contact NVA at 800-905-4102.

BlueCrossVision℠
Issued by
CAPITAL ADVANTAGE INSURANCE COMPANY®
A Capital BlueCross Company

VISION CARE CLAIM FORM

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
800-905-4102

PRINT ALL INFORMATION

PART A – TO BE COMPLETED BY EMPLOYEE

1. EMPLOYEE'S NAME (Last, First, Middle)	2. EMPLOYEE'S ADDRESS (No., Street, State, and Zip Code)
3. EMPLOYEE'S SOCIAL SECURITY NUMBER	4. TELEPHONE NUMBER
5. EMPLOYER NAME	6. EMPLOYER ADDRESS (No., Street, State, and Zip Code)

7. PATIENT'S NAME (Last, First, Middle)	8. PATIENT'S RELATIONSHIP TO EMPLOYEE	9. PATIENT'S SEX	10. PATIENT'S DATE OF BIRTH
	☐ Self ☐ Child ☐ Student ☐ Spouse ☐ Handicapped ☐ Other _____	☐ Male ☐ Female	

11. IS PATIENT COVERED FOR VISION CARE BY ANOTHER PLAN? ☐ NO ☐ YES	VISION PLAN NAME	GROUP NO.	NAME AND ADDRESS OF CARRIER

12.
Any person who knowingly and with intent to defraud any insurance company or other person; files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

13. SUBJECT TO THE TERMS AND CONDITIONS OF MY VISION BENEFITS PLAN, I HEREBY ASSIGN payment directly to the Doctor and/or Dispenser of the Vision Benefits otherwise payable to me. I understand that the plan will pay only the amount I am entitled to, and that any additional charges from the provider are my responsibility. Signature must be indicated on this claim form for assignment of payment to the Provider.

EMPLOYEE'S SIGNATURE _____ DATE _____

PART B – TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME (Last, First, Middle)	2. TAXPAYER IDENTIFICATION NO.	PROFESSIONAL SERVICES	AMOUNT
3. DOCTOR'S ADDRESS (No., Street, City, State, and Zip Code)		EYE EXAMINATION	

4. PHONE NO. (and Area Code)	5. TITLE ☐ M.D. ☐ D.O. ☐ O.D.	6. EXAMINATION DATE(S)	7. WAS CATARACT SURGERY PERFORMED? ☐ NO ☐ YES	CONTACT LENS EXAM (if any)	
8. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSES? ☐ NO ☐ YES		9. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? ☐ NO ☐ YES			
10. DIAGNOSTIC CODE(S)				AMOUNT PAID BY PATIENT	

11. INDICATE DIAGNOSIS OR NATURE OF DISEASE, INJURY, OR VISION DISORDER. CODE #'S INDICATE PROCEDURE	12. VISUAL ACUITY CORRECTED TO:

13.
DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
R.E.		●			
L.E.		●			
READING ADD		R.E.	+ ●	L.E.	+ ●

14. I hereby certify that I have performed the services as indicated heron.

DOCTOR'S SIGNATURE _____ DATE _____

PART C – TO BE COMPLETED BY DISPENSER

1. DISPENSER'S NAME (Last, First, Middle)	2. TAXPAYER IDENTIFICATION NO.
3. DISPENSER'S ADDRESS (No., Street, City, State, and Zip Code)	4. PHONE NO. (and Area Code)

5. PROFESSIONAL SERVICES:

	DATES(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS
1													
2													
3													
4													
5													
6													

6. PATIENT'S ACCOUNT NO.	7. TOTAL CHARGE	8. AMOUNT PAID	9. BALANCE DUE
	$	$	$

10. I hereby certify that I have performed the services as indicated hereon.

DISPENSER'S SIGNATURE _____ DATE _____

NVA-1 (1/2011)