

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

EMPLOYEE Please Complete This Section (Print)					
LAST NAME	FIRST	CARD MEMBER	S.S. NO.		
STREET ADDRESS		COMPLETE IF CLAIM FOR DEPENDENT			
		FIRST NAME	DATE OF BIRTH	SEX	STATUS
CITY	STATE	ZIP	SPONSOR NAME		<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED
IMPORTANT. I 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 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 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 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
STREET ADDRESS		DATE OF EXAM	
CITY	STATE	ZIP	CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.			DID PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? <input type="checkbox"/> YES <input type="checkbox"/> NO
SIGNATURE _____		DATE _____	DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES: CHANGES: AXIS _____ SPHERE OR CYLINDER _____ \$
I HAVE PRESCRIBED <input type="checkbox"/> SINGLE VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> APHAKIC <input type="checkbox"/> 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
CITY	STATE	ZIP	RIGHT			
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.			LEFT			
SIGNATURE _____		DATE _____		MATERIALS SUPPLIED		CHARGES
				NVA USE		
U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE		<input type="checkbox"/> SINGLE VISION				
TRADE NAME		WIDTH	<input type="checkbox"/> PAIR <input type="checkbox"/> ONE			
MANUFACTURER		SIZE	<input type="checkbox"/> GLASS <input type="checkbox"/> PLASTIC			
FRAME NUMBER		<input type="checkbox"/> PLASTIC <input type="checkbox"/> COMBINATION	<input type="checkbox"/> NEW			
		<input type="checkbox"/> METAL	<input type="checkbox"/> PATIENTS			
						TOTAL CHARGE