CLAIM FOR VISION CARE BENEFITS

MERITAIN HEALTH
Please submit this form to the address located on the back of your ID Card.

EMPLOYER _____

For ALL claims - this area must be filled out completely

EMPLOYEE

Employee's Name (Please Print Full Name)	Employee ID Number
Address	Employee's Date of Birth ___/___/___
City State Zip	☐ Single ☐ Married ☐ Widowed ☐ Divorced

If this is a new address, contact your employer's personnel office to activate changes.

If the patient is a dependent, please complete all of the following. If the patient is the employee, go directly to the area below the the shaded box.

PATIENT

Patient's name (if other than employee)	Patient's ID Number	
Patient's Date of Birth ___/___/___	Relationship to employee ☐ Spouse ☐ Child	If child, is (s)he married? ☐ Yes ☐ No

Is Patient Covered by Another Employer Group Plan or Retirement Group Plan? Yes☐ No☐ If yes, please furnish the following:

Name of employer: _____

Name and address of Insurance Company or Organization: _____

RELEASE

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud, submits an application for coverages or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Criminal and/or Civil penalties can result from such acts.

I hereby authorize payment of these benefits be sent directly to: ☐ **PROVIDER OF SERVICE** ☐ **EMPLOYEE** *(attach itemized bill or receipt)*

_____ _____

PATIENTS SIGNATURE *(Parent or Guardian if Claim is on a Minor)* **DATE**

THIS SECTION TO BE COMPLETED BY PROVIDER

EXAM

Indicate the nature of Disease, Injury or Vision Disorder:	Date of Examination:	Name of Provider performing services (please print)
Refraction? ☐ Yes ☐ No Contact Lenses? ☐ Yes ☐ No Tonometry? ☐ Yes ☐ No Cataract Surgery? ☐ Yes ☐ No		Address
Examination Charge: $	**Amount Paid by Employee:** $	City State Zip
Signature of Provider Degree/Title Date		Provider's Social Security or Tax ID Number *required by law*

LENSES

Date Ordered	Date Dispensed	☐ Pair ☐ 1/2 Pair			
	Sphere	Cylinder	Axis	Prism	Add
OD					
OS					

Type Lens: **Charge**

- ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Lenticular _____
- ☐ Contact Lenses _____
- ☐ Oversized Lenses _____
- ☐ Sunglasses _____
- ☐ Tint # _____
- ☐ Photosensitive - i.e. Brown, Gray, etc. _____
- ☐ Other _____

Lens Mfr. _____

LENS CHARGE $

FRAMES

Date Ordered	Date Dispensed	Parts ☐ Complete ☐ Partial
FRAME CHARGE	$	

Name of Provider performing services (please print)

Address

City State Zip

Provider's Social Security or Tax ID Number

Signature of Provider Degree/Title Date

Total Charge: $ **Amount Paid by Employee:** $

IMPORTANT: **CLAIMS CANNOT BE PAID UNTIL THE CLAIM FORM IS PROPERLY COMPLETED AND RECEIVED.**
Do not send this form through your employer. **ATTACH PROVIDER BILLING.**

If you require assistance in presenting this claim, call your Service Delivery Team at the number listed on your healthcare I.D. card.

vision.1/00

VISION SCHEDULE OF BENEFITS – ALL PLANS

BENEFIT DESCRIPTION	BENEFIT
Eye Exam Maximum Benefit per 12 Month Period	100% 1 exam up to $100*
Lenses, one pair, per 12 Month Period	100% up to:
Single Vision	$150*
Bifocal	$150*
Trifocal	$150*
Lenticular	$150*
Contact lenses One pair of lenses or one pair of contact lenses per 12 month period. Disposable contacts will be payable up to the maximum benefit for contacts, but will not be subject to the "one pair of lenses" maximum.	$150*
Frames Maximum Benefit per 24 Month Period	100% 1 pair up to $100*
*Dollar maximum does not apply to Dependent Children under age 19.	