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) Last First Middle Initial	Employee ID Number
Address	Employee's Date of Birth Month / Day / Year
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) Last First Middle Initial	Patient's ID Number	
Patient's Date of Birth Month / Day / Year	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.