

# eye care

## group claim form

Group Claims Adjusters / P.O. Box 82595 / Lincoln, NE 68501-2595  
Toll Free 800.659.5556 / Fax 402.467.7336 / Web firstameritasgroup.com



### PART 1 - TO BE COMPLETED BY EMPLOYEE

1. Patient's full name (first, middle initial, last)		2. Patient birthdate (MM/DD/YY)		3. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other		4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
5. Employee's full name (first, middle initial, last)		6. Employee's identification number		Employee's birthdate (MM/DD/YY)			
7. Employee's mailing address (Street address or P.O. Box, City, State, ZIP)				8. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER Is patient a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, name and address of school			
9. Employer (company) name and address		10. Group number		Division number		Certificate number	
QUESTIONS 11 AND 12 MUST BE COMPLETED WITH EACH CLAIM SUBMISSION							
11. Is patient covered by another eye care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and address of other carrier		Policy number		Name and address of other employer	
12. Other employee/subscriber name		Employee/subscriber identification number		Date of birth (MM/DD/YY)		Relationship to patient	
13. I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of treatment. I certify these statements to be true and complete to the best of my knowledge.				14. I hereby authorize payment directly to the below named provider of group insurance benefits otherwise payable to me.			
X Signature (patient, or parent if minor)		Date		X Signature (insured person)		Date	

It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and/or civil penalties can result from such acts.

### PART 2 - TO BE COMPLETED BY ATTENDING EYE CARE PROVIDER.

15. Eye care provider name and mailing address		For Yes answers to questions 17-19, enter a brief description and date.	
		17. Is treatment result of occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		18. Is treatment result of auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Specialty	Phone number	19. Other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email	Fax number	20. This is a (please check one): <input type="checkbox"/> Statement of actual services <input type="checkbox"/> Pretreatment estimate	
16. Federal tax ID number <input type="checkbox"/> SSN <input type="checkbox"/> TIN	NPI (National Provider Identifier)	21. Is this for LASIK/PRK? <input type="checkbox"/> Yes <input type="checkbox"/> No	
License #			

22. EXAMINATION AND TREATMENT RECORD Please include date of service, description of services, procedure code and fee.							
Date service performed (MM/DD/YY)	Description of services	CPT/HCPCS procedure code	Diagnosis code	LASIK PRK	Left eye	Right eye	Fee

23. Remarks							24. Total \$
-------------	--	--	--	--	--	--	--------------

25. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.	26. Address where treatment was performed
X Signature (Provider) _____ Date _____	

# tips

## how to speed claims processing

### part 1 – employee

Missing or incomplete information will slow down claims processing. To avoid this, please be sure to include:

**#2 Patient birthdate**

Helps identify an insured and determine dependent eligibility.

**#6 Employee's identification number**

This is the most important identifier for the plan member.

**#8 Student status**

Because this information often changes, it is required on every claim for dependents age 19 years and older.

**#11 and #12 Coordination of benefits**

The No box under #11 should be checked if no other eye care coverage exists. If there is other eye care coverage, the additional information requested is necessary for coordination of benefits.

**#21 and #22 LASIK/PRK**

If LASIK or PRK, please make sure your eye care provider marks the Yes box under #21, and includes description of services, procedure code, which eye (left, right or both), and the fee for each eye in the Examination and Treatment Record.

### part 2 – eye care provider

To help expedite the claims process, please be sure to include:

**#16 National Provider Identifier**

There are two types of NPI. Type 1 is for individual providers who operate independently. Type 2 is for health care providers such as group practices or corporations. Type 2 organization providers may want their individual provider employees to have Type 1 NPIs to distinguish them individually.

**#20 Statement of actual services, or Pretreatment estimate**

Appropriate box should be marked to ensure correct handling.

**NOTE:** If there are two different providers (one for the exam, another for eyewear), we request that each provider submit a separate claim form.

abbreviations	
VE	vision exam
FR	frame
SV	single vision lenses
BI	bifocal lenses
TR	trifocal lenses
LE	lenticular lenses
PP	progressive lenses
CD	contacts
CN	necessary contacts
CC	cosmetic contacts

### pretreatment estimate of benefits

We recommend a pretreatment estimate of benefits when a plan member considers the services to be expensive. A pretreatment estimate lets both the member and eye care provider know in advance how much insurance will pay. If eye care coverage terminates for any reason during treatment, only procedures performed before coverage ended will be eligible for payment.

For full information regarding coverage, plan members may refer to their insurance plan booklet.

### website

Visit our website for benefit information, electronic forms, a list of eye care providers if your plan includes a network, and more. Please note, the free software Adobe Reader® (available through the internet) is needed to view and print the electronic forms.