

MAILING ADDRESS:
P.O. Box 3187
Tuscaloosa, Alabama 35403



VISION CLAIM FORM

CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 365 DAYS FROM DATE OF SERVICE.

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
6. PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street)									
CITY STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
ZIP CODE TELEPHONE (Include area code)		CITY STATE									
8. PATIENT STATUS Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part Time Student <input type="checkbox"/>		ZIP CODE TELEPHONE (Including Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH SEX M <input type="checkbox"/> F <input type="checkbox"/> MM DD YY		b. EMPLOYERS NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d									
11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of benefits to the undersigned physician or supplier for services described below. SIGNED _____									
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)											
1. _____		3. _____									
2. _____		4. _____									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. Place of Service		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS	
1											
2											
3											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER SSN <input type="checkbox"/> EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.				28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION A. _____ B. _____				33. BILLING PROVIDER INFO & PH. # () A. _____ B. _____					