

# EYE CARE GROUP CLAIM FORM

Group Claim Office / P.O. Box 82520, Lincoln, NE 68501  
Toll Free No.: 800-255-4931 / www.ameritasgroup.com



PLEASE BE AS COMPLETE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM.  
ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

## PART A - TO BE COMPLETED BY INSURED

1. PATIENT'S NAME (Last, First, Middle)		2. PATIENT'S BIRTHDATE		3. PATIENT'S SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
5. INSURED'S NAME (Last, First, Middle)			6. INSURED'S SOCIAL SECURITY NO.		7. INSURED'S BIRTHDATE		
8. INSURED'S STREET ADDRESS				9. NAME OF EMPLOYER / GROUP NUMBER			
10. CITY, STATE, ZIP CODE							
11. IS PATIENT COVERED FOR EYE CARE BY ANOTHER PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please complete boxes 12 through 16.				12. NAME AND ADDRESS OF OTHER CARRIER			
13. INSURED'S NAME		14. RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		15. INSURED'S BIRTHDATE		16. INSURED'S SSN / GROUP NUMBER	

**17. 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?  Yes  No. If YES, Name and Address of School \_\_\_\_\_

<p>I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO AMERITAS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.</p> <p>SIGNATURE OF INSURED _____ DATE _____</p>	<p>I HEREBY AUTHORIZE <b>PAYMENT</b> FOR ANY BENEFITS TO THE BELOW NAMED DOCTOR/DISPENSER.</p> <p>SIGNATURE OF INSURED _____ DATE _____</p>
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**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 B - TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME (Last, First, Middle)			2. TITLE <input type="checkbox"/> D.O. <input type="checkbox"/> M.D. <input type="checkbox"/> O.D.			
3. DOCTOR'S STREET ADDRESS				4. CITY, STATE, ZIP CODE		
5. PHONE ( )	6. WERE EYEGLASSES PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE CONTACTS PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO		7. HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		8. EXAMINATION DATE PLEASE ENTER EXAMINATION CHARGE IN FEE COLUMN BELOW (BLOCK 12.)	
9. ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Doctor's Tax I.D. # _____		10. I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON. DOCTOR'S SIGNATURE _____ DATE _____				
11. DIAGNOSIS OR NATURE OF OFFICE VISIT					12. EXAMINATION CHARGE	AMOUNT

## PART C - TO BE COMPLETED BY DOCTOR/DISPENSER

FRAME												CHECK APPROPRIATE BOX				FRAME CHARGE	
SIZE & MODEL		MFG.		ZYL	METAL	RIMLESS	COMBO										
LENSES		# OF LENSES	GLASS	PLASTIC	SV	BIF	TRI	PAL	SAFETY	OTHER			LENS CHARGE				
LENS OPTIONS		OS	TINT	GRAD	DBL GRAD	COAT	UV400	FACET	PHOTO CHROMIC	OTHER			OPTIONS CHARGE				
CONTACT LENSES		# OF LENSES	HCL	SCL	HGP	DISPOS-ABLE	SPH	BIF	TORIC	EW	TINT	NUMBER REPLACED	OTHER	CONTACT CHARGE			
DATE ORDERED				DATE DISPENSED				OTHER SERVICES				OTHER SERVICES					
DISPENSING OFFICE										PHONE ( )				SUBTOTAL			
ADDRESS			STREET			CITY			STATE			ZIP		SALES TAX (If Applicable)			
ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Dispensers Tax I.D. Number _____														TOTAL CHARGES			
I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.														AMOUNT PAID BY PATIENT			
DISPENSER'S SIGNATURE _____										DATE _____							

## Instructions

- A. Please print or type the insured portion of this form, in full, to assure prompt reimbursement. The insured should sign and date this form when work is completed.
- B. If two different providers are involved in providing the examination and the frame, lenses or contact lenses, then each provider should complete the appropriate section of the form.
- C. After the form has been fully completed it should be mailed to the address shown on front of form.

### ABBREVIATIONS

#### FRAME

MFG .....manufacturer  
ZYL.....plastic  
COMBO .....combination (Zyl/Metal)

#### LENSES

SV .....single vision  
BIF .....bifocal  
TRI .....trifocal  
PAL .....progressive add lenses

#### LENS OPTIONS

OS .....oversize  
GRAD .....gradient

#### CONTACT LENSES

HCL.....hard contact lenses  
SCL .....soft contact lenses  
HGP .....hard gas permeable  
SPH .....spherical  
BIF .....bifocal