Group Vision Claim Form

Submit Claims to: P.O. Box 5490 • Salem, OR 97304 • 800.893.9230

1. Your Policy and/or Group number(s)			
2. Name and address of employer			
EMPLOYEE INFORMATION			
3. Name of employee *(insured)*	☐ Male ☐ Female	Date of Birth	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
4. Address of employee Street City State Zip Code			5. Employee's SS number
6. Other Vision Insurance Coverage? ☐ Yes ☐ No If yes, please provide the name of employer and the address of Insurance Company.			
IF CLAIM FOR DEPENDENT, COMPLETE THIS SECTION ALSO			
7. Name of your dependent	☐ Male ☐ Female	Date of Birth	Is dependent a full-time student? ☐ Yes ☐ No

COMPLETE FOR VISION SERVICES OR ATTACH ITEMIZED BILL

8. Date of Service	Service Rendered	Charge

9. Physician or Optometrist Name	Address Street City State Zip Code
10. Tax ID Number	11. Signature of Physician or Optometrist Date Signed

COMPLETE FOR VISION SUPPLIES OR ATTACHE ITEMIZED BILL

12. Lenses Charge:	☐ One Eye ☐ Both Eyes ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Bifocal ☐ Other
13. Frames Charge	14. Are existing Frames being used for new lenses? ☐ Yes ☐ No If no, why?
15. Suppliers Name	Address Street City State Zip Code
16. Tax ID Number	Signature of Supplier Date Signed

IMPORTANT – PLEASE COMPLETE AUTHORIZATION SECTION

13. AUTHORIZATION TO RELEASE INFORMATION:
The above answers are true and correct to the best of my knowledge. I hereby authorized any physician, surgeon, practitioner or other person, any hospital, including veterans administration or government hospital, any medical service organization, and insurance company, or any other information acquired, including benefits paid or payable, concerning this or other disabilities. A Photostat of this authorization shall be as valid as the original.

Signed (Patient or Parent if Minor) Date

14. AUTHORIZATION TO PAY INSURANCE BENEFITS:
I hereby authorize payment directly to the Physician named above those benefits otherwise payable to me but not to exceed the Physician's regular charges. I understand I am financially responsible to the Physician for charges not covered by this authorization.

Signed (Patient or Parent if Minor Date

Please attach itemized bills to this form and mail to: PH Tech