The HealthPlan

VISION BENEFITS CLAIM FORM

Please submit your billing along with this claim form to our Plan Administrator at:
The Health Plan, 1110 Main Street, Wheeling, WV 26003
1.888.816.3096

Employer:

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. Patient's Name (First, Middle Initial, Last Name)	2. Patients Date of Birth	3. Insured's Name (First, Middle Initial, Last Name)
4. Patient's Address (Street, City, State, Zip Code)	5. Patient's Gender ◯ Male ◯ Female	6. Insured's I.D. Number
	7. Patient's relationship to insured	8. Insured's Group Number (Or Group Name)
9. OTHER HEALTH INSURABCE COVERAGE--Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. Was condition related to: ◯ A. Patient's employment ◯ B. An auto accident	11. Insured's Address (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any Medical information necessary to process this claim and request payment of Medicare Champus benefits either to myself or to the party who accepts assignment below Signed _____ Date _____		13. I authorize payment of Medical Benefits to undersigned physician or supplier for services described below.

Did visual analysis indicate a change in prescription from the immediately preceding prescription? ◯ Yes ◯ No

Services		Charges
Exam	Date of Service	$
Lenses	Date of Service Type of Lenses: ◯ Single ◯ Bifocal ◯ Trifocal Were Lenses: ◯ Tinted ◯ Sunglasses/Safety Glasses ◯ Other	$
Frames	Date of Service	$
Contacts	Date of Service Please advise reason for contacts (severe corneal astigmatism, severe corneal scarring, or patient prefers contacts etc.)	$

INDIVIDUAL PRACTIONERS-SS#				Total	$
ALL OTHERS-EMPLOYER IRS#				Amount Paid	$
Must be furnished under authority of law				Balance Due	$

Date Physician's Name Signature

Physician's SSN# or EIN# NPI# Phone#

Street Address City/Town State Zip Code