BlueCross*Vision*℠

Issued by
CAPITAL ADVANTAGE INSURANCE COMPANY®
A Capital BlueCross Company

CLAIM FOR VISION CARE EXPENSE
FOR NON-PARTICIPATING PROVIDERS

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
800-905-4102

TO BE COMPLETED BY EMPLOYEE (*Print*)

SUBSCRIBER INFORMATION			PATIENT INFORMATION			
LAST NAME	FIRST NAME		SUBSCRIBER ID (SSN OR ID#)			
STREET ADDRESS			PATIENT LAST NAME	PATIENT FIRST NAME		
CITY	STATE	ZIP CODE	DATE OF BIRTH	GENDER	STATUS	
			/ /	MALE ☐ FEMALE ☐	SPOUSE ☐ CHILD ☐	

I HEREBY CERTIFY THAT THE PATIENT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FOR THE BENEFITS AND THAT I HAVE RECEIVED THE SERVICES DESCRIBED. I ALSO CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN ON THE JOB INJURY OR COVERED UNDER ANOTHER VISION PROGRAM. I FURTHER AUTHORIZE THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITER, POLICY HOLDER AND THE EMPLOYER.

EMPLOYEE'S SIGNATURE _____ DATE _____

IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? ☐ YES ☐ NO
2) SAFETY GLASSES? ☐ YES ☐ NO 3) CATARACT SURGERY? ☐ YES ☐ NO IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN THE SPACE PROVIDED.

IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? ☐ YES ☐ NO IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE SPACE PROVIDED.

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST (*Print*)

EXAMINER NAME ☐ MD ☐ OD	TAX ID#	PATIENT NAME	DATE OF EXAM
STREET ADDRESS		CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL EYEGLASSES? ☐ YES ☐ NO	
CITY	STATE ZIP CODE	DOES PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? ☐ YES ☐ NO	
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON. SIGNATURE_____ DATE_____		DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? ☐ YES ☐ NO IF YES, CHANGES: AXIS_____ SPHERE/CYLINDER_____	SERVICE CHARGE $

I HAVE PRESCRIBED: ☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ APHAKIC CONTACTS: ☐ HARD ☐ SOFT ☐ COSMETIC ☐ MEDICALLY REQUIRED

TO BE COMPLETED BY DISPENSER (*Print*)

DISPENSER NAME	TAX ID#	PATIENT NAME	DATE OF SERVICE
STREET ADDRESS			
CITY	STATE ZIP CODE		

Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD
RIGHT					
LEFT					

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.

SIGNATURE_____ DATE_____

LENSES

U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE

TRADE NAME WIDTH ☐ PAIR ☐ ONE ☐ GLASS ☐ PLASTIC

FRAMES

MANUFACTURER NAME SIZE MODEL OR STYLE

FRAME NUMBER ☐ PLASTIC ☐ METAL ☐ COMBINATION ☐ NEW ☐ PATIENT'S

MATERIALS SUPPLIED	CHARGES	NVA USE
☐ SINGLE VISION		
☐ BIFOCAL		
☐ TRIFOCAL		
☐ APHAKIC		
☐ CONTACTS ☐ HARD ☐ SOFT		
☐ TINT #_____ COLOR_____		
☐ OTHER _____		
FRAME		
TOTAL CHARGE		

CLAIM INSTRUCTIONS

EMPLOYEE:

- Use this form to obtain reimbursement for services.
- Complete the employee section of the form.
- Sign and date the form after checking for completeness.
- Attach a copy of itemized receipts.
- Submit the form to:

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If you have any questions, please contact BlueCross *Vision* at 800-905-4102