GROUP VISION CLAIM FORM

bac

INSTRUCTIONS: ANSWER ALL QUESTIONS FULLY, ATTACH ITEMIZED BILLING, AND FORWARD TO BAC AT: PO BOX 107, REYNOLDSBURG, OH 43068-0107 FOR PROCESSING.

A. STATEMENT OF COVERED PARTICIPANT: PLEASE ANSWER ALL QUESTIONS FULLY

1. EMPLOYEE'S NAME (LAST, FIRST, M.): | DATE OF BIRTH (MM/DD/YYYY): | SOCIAL SECURITY NUMBER:

2. HOME ADDRESS: | CITY: | STATE: | ZIP CODE:

3. SEX: ◯ MALE ◯ FEMALE | MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED | IS THIS A NEW ADDRESS?: ◯ YES ◯ NO

4. EMPLOYER: | STATUS: ◯ ACTIVE ◯ RETIRED ◯ COBRA

5. SPOUSE'S NAME (LAST, FIRST, M.): | SPOUSE'S D.O.B. (MM/DD/YYYY): | SPOUSE'S SOCIAL SECURITY NO.

6. IS SPOUSE EMPLOYED?: ◯ YES ◯ NO | SPOUSE'S EMPLOYER:

ADDRESS OF SPOUSE'S EMPLOYER: | CITY: | STATE: | ZIP CODE:

7. ARE YOU OR YOUR DEPENDENT COVERED UNDER ANY OTHER GROUP VISION PLAN (INCLUDING BLUE CROSS & BLUE SHIELD), STUDENT OR GOVERNMENT PLAN? ◯ NO ◯ YES – PLEASE, COMPLETE NEXT 4 FIELDS

NAME OF OTHER INSURANCE COMPANY: | PLAN NUMBER:

ADDRESS OF OTHER INSURANCE COMPANY: | EFFECTIVE DATE:

B. CLAIM FOR DEPENDENT: (COMPLETE THIS SECTION IN ADDITION TO QUESTIONS 1-7)

8. DEPENDENT'S NAME (LAST, FIRST, M.): | DATE OF BIRTH (MM/DD/YYYY): | SOCIAL SECURITY NUMBER:

9. DOES DEPENDENT RESIDE WITH EMPLOYEE: ◯ YES ◯ NO, PROVIDE ADDRESS: | RELATIONSHIP TO EMPLOYEE:

10. IS DEP. EMPLOYED: ◯ NO ◯ F-T ◯ P-T | IS CHILD MARRIED: ◯ YES ◯ NO | IF OVER 19, IS CHILD A FULL-TIME STUDENT: ◯ NO ◯ YES, WHERE: | DATE OF CURRENT ENROLLMENT:

C. AUTHORIZATIONS: (PLEASE CHECK ONLY THE OPTONS THAT APPLY AND SIGN AT BOTTOM)

11. **I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, INSURANCE COMPANY, EMPLOYER, OR ORGANIZATION TO RELEASE ANY INFORMATION REGARDING THE MEDICAL HISTORY, TREATMENT, DISABILITY, OR BENEFITS PAYABLE. A PHOTO-STAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. THIS AUTHORIZATION SHALL EXTEND TO MY SPOUSE AND DEPENDENTS.**

EMPLOYEE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): X | **DATE SIGNED** (MM/DD/YYYY):

SPOUSE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): X | **DATE SIGNED** (MM/DD/YYYY):

12. **AUTHORIZATION TO PAY BENEFITS TO PROVIDER:** I HEREBY AUTHORIZE PAYMENT FOR VISION SERVICES, IF ANY, DIRECTLY TO THE PROVIDER BUT NOT TO EXCEED THE SCHEDULED AMOUNT, OR THE REASONABLE AND CUSTOMARY CHARGES. **PLEASE NOTE:** FAILURE TO SIGN THIS SECTION DOES NOT GUARANTEE THAT PAYMENT WILL BE MADE TO YOU DUE TO PPO CONTRACTUAL REQUIREMENTS.

EMPLOYEE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): X | **DATE SIGNED** (MM/DD/YYYY):

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

PLEASE, HAVE YOUR PROVIDER COMPLETE ALL INFORMATION ON BACK OF PAGE

D. PROVIDER INFORMATION (THIS SECTION TO BE COMPLETED BY PROVIDER – PLEASE PRINT):

TO BE COMPLETED BY PROVIDER

PATIENT NAME (LAST, FIRST, M.):	DATE OF EXAM (MM/DD/YYYY):

REFRACTION:	TONOMETRY:	CONTACT LENSES:	CATARACT SURGERY:
◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO

IF CONTACT LENSES WERE PRESCRIBED, PLEASE INDICATE:
◯ **COSMETIC** ◯ **MEDICALLY NECESSARY**

DATE ORDERED (MM/DD/YYYY)		SPHERE	CYLINDER	AXIS	PRISM	ADD
	OD:					
	OS:					

MATERIALS SUPPLIED:	SEG. STYLE/WIDTH:
◯ **PLASTIC** ◯ **GLASS** ◯ **PAIR** ◯ **1/2 PAIR**	

CHOOSE ONE:
◯ **EXECUTIVE** ◯ **FLATTOP** ◯ **ROUND** ◯ **VELALUX** ◯ **PANOPTIC** ◯ **KRYPTOK** ◯ **FLATTOP 28/35** ◯ **OTHER:**

PLEASE CHECK APPROPRIATE BOXES AND INDICATE APPLICABLE CHARGES:

LENS DETAILS:	CONTACT LENS DETAILS:	CHARGES (INCLUDE TAX):
TYPE OF LENS: ◯ **SINGLE VISION** ◯ **BIFOCAL** ◯ **TRIFOCAL** ◯ **LENTICULAR**	**TYPE OF LENS:** ◯ **HARD** ◯ **GAS PERMEABLE** ◯ **DISPOSABLE** ◯ **SOFT** ◯ **EXTENDED WEAR**	
OVER SIZED: ◯ **NO** ◯ **YES**	**FITTINGS:** ◯ **NO** ◯ **YES**	
SUNGLASSES: ◯ **NO** ◯ **YES**	**SOLUTIONS:** ◯ **NO** ◯ **YES**	
TINT NUMBER: **GRADIENT:**	**CARE KIT:** ◯ **NO** ◯ **YES**	
PHOTOSENSATIVE (I.E. BROWN, GREY, ETC.)**:**	**INSURANCE:** ◯ **NO** ◯ **YES**	
OTHER (PLEASE EXPLAIN)**:**	**OTHER** (PLEASE EXPLAIN)**:**	
LENS MANUFACTURER:	**LENS MANUFACTURER:**	

PROVIDER INSTRUCTIONS:

Please either submit an itemized bill, or complete this section and mail to:

BAC
PO BOX 107
REYNOLDSBURG, OH
43068-0107

EXAM CHARGE:	$:
LENS CHARGE:	$:
FRAME CHARGE (INCLUDING TAXES):	$:
OTHER CHARGES:	$:
TOTAL CHARGE (INCLUDING TAXES):	$:
TOTAL AMOUNT PAID BY PATIENT:	$:

NAME OF PROVIDER WHO PERFORMED THE SERVICES:

PROVIDER'S MAILING ADDRESS: CITY: STATE: ZIP CODE:

EMPLOYER I. D. NUMER:	SOCIAL SECURITY NUMBER:

PROVIDER'S AUTHORIZATION:

X _____ _____
PROVIDERS'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DEGREE/TITLE:** **DATE SIGNED** (MM/DD/YYYY):