VISION CARE
CLAIM FORM

CLAIMS ADMINISTRATOR
PO BOX 1349, WAKE FOREST, NC 27588 * FAX 919-562-0021

PATIENT & SUBSCRIBER INFORMATION		
1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH / /	3. SUBSCRIBER'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, zip code)	5. PATIENT"S SEX MALE ☐ FEMALE ☐	6. SUBSCRIBER'S ID
	7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8. SUBSCRIBER'S GROUP NUMBER (OR GROUP NAME)
9. OTHER HEALTH (VISION) INSURANCE COVERAGE	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ☐ NO ☐ B. ACCIDENT YES ☐ NO ☐	11. SUBSCRIBER'S ADDRESS (Street, city, state, zip code)

PROFESSIONAL SERVICES

PROCEDURES/SUPPLIES	**DATE OF SERVICE**	**CHARGES**
12. Visual Analysis/Examination:		
13. Lenses: Single Vision		
14. Bifocal Vision		
15. Trifocal Vision		
16. Contact Lens: (**after cataract surgery)**		
17. Contact Lens: (**other than after cataract surgery – note: one lens or two lenses)**		
18. Frames:		
19. Diagnosis:		

20.

OLD PRESCRIPTION

	Sphere	Cyl.	Axis
R			
L			
Add R			
Add L			

NEW PRESCRIPTION

	Sphere	Cyl.	Axis
R			
L			
Add R			
Add L			

21. SIGNATURE OF PHYSICIAN OR SUPPLIER

SIGNED DATE

22. YOUR PATIENT ACCOUNT NUMBER

23. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NUMBER.

Tax I.D. number: