luminare health℠
Experience. Solutions. Results.

VISION CLAIM FORM

INSTRUCTIONS FOR COMPLETING FORM

- COMPLETE PART A. BEING SURE TO SIGN AND DATE THE FORM IN EACH OF THE APPROPRIATE SPACES.
- HAVE YOUR DOCTOR COMPLETE PART B OR ATTACH AN ITEMIZED BILL.
- HAVE PERSON FILLING PRESCRIPTION COMPLETE PART C.
- SEND CLAIM TO ADDRESS LISTED BELOW.

PART A — TO BE COMPLETED BY EMPLOYEE (ANSWER ALL QUESTIONS TO AVOID DELAY)

1. Name of Employee (Print last name, then first name)

2. Home Address

3. Claim is made for **MYSELF** ☐ **SPOUSE** ☐ **CHILD** ☐

Patient's name (if other than self) — Patient's Date of Birth / /

Patient's occupation

4. Is treatment the result of an accident? YES ☐ NO ☐

Date of Accident _____ 20____, Time _____

Did accident happen at work? YES ☐ NO ☐

Describe how accident happened _____

5. **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Legally Sep.** ☐

6. Employee's Date of Birth / /

7. _____ Employee's I.D. Number use last 4 SSN

8. A. Is your spouse/dependent employed? YES ☐ NO ☐ If yes, give:

B. Spouse Name _____

C. Employer Name _____

D. Employer Address _____

9. Do you, your spouse or children have coverage under any vision plan other than with this plan?

YES ☐ NO ☐

A. If "Yes", give name of other insurance company(ies) and claim office address

B. Is this coverage provided on a group ☐ or individual ☐ basis?

C. Name and address of employer, union, school or organization through which this coverage is arranged.

D. Policy Number _____

10. Employment Status

Active ☐ Retired ☐ Laid Off ☐ Disability Leave ☐ Other ☐

11. EMPLOYER'S NAME West Chester Area School District

12. GROUP NUMBER 6104

13. AUTHORIZATION TO PAY BENEFITS TO PROVIDER I hereby authorize payment directly to the undersigned Provider of the vision benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

SIGNED (PATIENT, OR PARENT IF MINOR) Only sign here if payment should be sent to Provider **DATE**

14. I certify that the above statements and answers, including any accompanying bills and statements are true and complete to the best of my knowledge and belief. I authorize the release to and the use by LUMINARE of any medical or other information needed in processing this claim. A photocopy of this authorization shall be as valid as the original.

Date _____ Signature of Employee _____

Please mail Claim Statement to:

Luminare
P.O. Box 2920
Clinton, IA 52733-2920
Telephone: 1-800-223-3943

BP12464/woflex

PART B EXAMINING OPHTHALMOLOGIST'S OR OPTOMETRIST'S STATEMENT

Diagnosis on Nature of Disease, Injury or Vision Disorder

Is the condition due to injury or sickness arising out of patient's employment?

☐ YES ☐ NO If yes, explain

Report of Services (Or attach itemized bill)

Dates of Services	Services Rendered	Charges

Fee For

LENSES $ _____ TOTAL CHARGES ▶ _____ BALANCE DUE

FRAMES $ _____ AMOUNT PAID ▶ _____ _____

CONTACTS $ _____

Did patient have glasses prior to this examination?

☐ YES ☐ NO If yes, what type? ☐ Lenses in Frames ☐ Hard Contact ☐ Soft Contacts

Does patient require a lens prescription change at this time?

☐ YES ☐ NO If yes, why?

Are new frames required?

☐ YES ☐ NO

Materials prescribed (Check appropriate boxes and indicate number prescribed)

☐ Frames _____ ☐ Bifocal _____ ☐ Contact Lenses Hard _____ Soft _____

☐ Single Vision _____ ☐ Trifocal _____ ☐ Other _____

If Tinted Lenses, Sunglasses and/or Safety Glasses prescribed, please explain

Date **Type or Print Full Name** **Degree**

INDIVIDUAL PRACTITIONER'S SS# _____ _____ _____

Provider's Signature **Telephone**

ALL OTHERS-EMPLOYER I.D. # _____ _____

Must be furnished under Authority of Law

Street Address **City or Town** **State** **Zip Code**

PART C TO BE COMPLETED BY DISPENSER OF PRESCRIPTION – IF DIFFERENT FROM EXAMINING DOCTOR

(Or Attach Itemized Statement)

Date of Delivery

Fee For:

LENSES $ _____ FRAMES $ _____ CONTACTS $ _____

Type or Print Full Name

INDIVIDUAL PRACTITIONER'S SS# _____ _____ _____

Dispenser's Signature **Telephone**

ALL OTHERS-EMPLOYER I.D. # _____ _____

Must be furnished under Authority of Law

Street Address **City or Town** **State** **Zip Code**