

## **CLAIM INSTRUCTIONS**

- 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:

NATIONAL VISION ADMINISTRATORS  
P.O. BOX 2187  
CLIFTON, NEW JERSEY 07015

If you have any questions, please contact BlueCross Vision at 800.905.4102

On behalf of Capital BlueCross, National Vision Administrators, LLC (NVA<sup>®</sup>) provides the network and assists in the administration of network management services for the BlueCross Vision benefits program. NVA is an independent company.

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## 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 ( <i>Print</i> )					
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
			/	/	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
				SPOUSE <input type="checkbox"/>	CHILD <input type="checkbox"/>
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)? <input type="checkbox"/> YES <input type="checkbox"/> NO 2) SAFETY GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO    3) CATARACT SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO    IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE SPACE PROVIDED.					

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST ( <i>Print</i> )						
EXAMINER NAME		<input type="checkbox"/> MD <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO			
CITY	STATE	ZIP CODE	DOES PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.			DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO    IF YES, CHANGES:		SERVICE CHARGE	
SIGNATURE _____		DATE _____		AXIS _____	SPHERE/CYLINDER _____	
I HAVE PRESCRIBED: <input type="checkbox"/> SINGLE VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> APHAKIC    CONTACTS: <input type="checkbox"/> HARD <input type="checkbox"/> SOFT <input type="checkbox"/> COSMETIC <input type="checkbox"/> MEDICALLY REQUIRED						

TO BE COMPLETED BY DISPENSER ( <i>Print</i> )					
DISPENSER NAME		TAX ID#	PATIENT NAME		DATE OF SERVICE
STREET ADDRESS			Rx	SPHERE	CYLINDER
CITY	STATE	ZIP CODE	RIGHT		
			LEFT		
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.			MATERIALS SUPPLIED	CHARGES	NVA USE
SIGNATURE _____			<input type="checkbox"/> SINGLE VISION		
			<input type="checkbox"/> BIFOCAL		
			<input type="checkbox"/> TRIFOCAL		
			<input type="checkbox"/> APHAKIC		
			<input type="checkbox"/> CONTACTS		
			<input type="checkbox"/> HARD <input type="checkbox"/> SOFT		
			<input type="checkbox"/> TINT # _____ COLOR _____		
			<input type="checkbox"/> OTHER _____		
L E N S E S	U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE		FRAME		
	TRADE NAME	WIDTH	<input type="checkbox"/> PAIR <input type="checkbox"/> ONE		
			<input type="checkbox"/> GLASS <input type="checkbox"/> PLASTIC		
F R A M E S	MANUFACTURER NAME	SIZE	MODEL OR STYLE	TOTAL CHARGE	
	FRAME NUMBER	<input type="checkbox"/> PLASTIC <input type="checkbox"/> METAL	<input type="checkbox"/> NEW		
		<input type="checkbox"/> COMBINATION	<input type="checkbox"/> PATIENT'S		