

VISION CARE CLAIM FORM

Administered by:

First Administrators, Inc.

P.O. Box 9900

Sioux City, Iowa 51102

1. Employer.	Name of Employer		Group No. as Shown on Your I.D. Card		
2. Claimants statement. <small>(one claim form per patient)</small>	Employee's Full Name (Last, First, Middle Initial)		Employee's Social Security No.		
	Employee's Address		Employee's Date of Birth Month Day Year		
	City	State	Zip Code	Area Code and Phone No. ()	
	Patient's Name	Relationship to Employee	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient's Date of Birth Month Day Year	
	Name of Spouse		Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Name of Spouse's Employer		Address		
	Is patient covered under any other group Health Insurance Plan provided through an employer, a union, any Federal, State, Provincial or other Government program including Blue Cross and Blue Shield? <input type="checkbox"/> Yes* <input type="checkbox"/> No				
	*IF YES	Name of Policyholder		Type of Coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	
		Name of Insurance Company		Identification No.	
		Address of Insurance Company		City State	
Accident Information.	Is claim due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "yes", where did accident occur?		
	Describe Accident		Date of Accident Month Day Year		
3. To be completed by provider or Attach statement with -Service Dates -Services Provided -Amount Charged -Diagnosis/Illness	Describe disease, injury or vision disorder.				
	Did the condition arise out of the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did patient have glasses or contact lenses prior to this exam? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Did patient require a lens prescription change? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can vision be corrected to at least 20/70 using spectacle lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Explain if tinted/sun/safety lenses were prescribed.				
	Materials prescribed (check appropriate box(es) and indicate a number prescribed).				
	<input type="checkbox"/> Frames _____ <input type="checkbox"/> Single Lens _____ <input type="checkbox"/> Bifocal _____ <input type="checkbox"/> Trifocal _____ <input type="checkbox"/> Contacts _____ <input type="checkbox"/> Other _____				
	Date of Service	Procedure Code	Describe Procedure or Medical Services Rendered		Charge
MATERIALS PURCHASED (OR ATTACH ITEMIZED STATEMENT)					
Date	<input type="checkbox"/> Frames <input type="checkbox"/> Lenses	<input type="checkbox"/> Contacts	\$ _____		
	•Single \$ _____				
	•Bifocal \$ _____				
	•Multifocal \$ _____	<input type="checkbox"/> Other	\$ _____		
Address		City	State	Zip Code	
4. Authorization to obtain information.					
To: Any physician, medical practitioner, hospital, clinic or other medical or medically related facility or provider of medical services or supplies, and any employer, group policyholder, or contract holder or insurer. I authorize you to release to First Administrators, Inc. or its representatives any and all information you may have about the mental and physical history, condition and treatment, and insurance coverage of:					
X _____ (patient)					
I understand the information obtained by use of Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by First Administrators, Inc. to any person or organization EXCEPT to reinsuring companies, Group Policyholder, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required or as I may further authorize. For the purpose of disclosing information, I understand that this authorization is valid for a period of one year. I know that I may request a copy of this authorization. If this authorization is given in connection with a claim for health benefits, disability or life insurance benefits, I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original.					
X _____ Signature of Parent or Guardian		X _____ Date	X _____ Relationship to Patient Signed by Guardian		
5. Assignment of benefits. <small>(Complete this section only when you wish payment to be made directly to the provider of service.)</small>					
Provider's Name (Hospital, Doctor, etc.)			Tax No.		
Street Address			Provider Telephone No. ()		
City	State	Zip Code			
Employee's Signature only if Benefits are Assigned:					
X _____				Date X _____	

INSTRUCTIONS

for proper completion of your claim form

- Complete Step 1.** – Employer Name
- Complete Step 2.** – The Claimants Statement
- Complete Step 2.** – (One patient per claim form)
- Complete Step 3.** – Have your doctor or hospital representative fill out step 3 and sign it, or attach an itemized statement. Diagnosis must be included on the statement.
- Complete Step 4.** – Authorization — please sign and date.
- Complete Step 5.** – Assignment of Benefits — ONLY IF YOU WISH PAYMENT TO BE MADE DIRECTLY TO THE PROVIDER — complete in full and sign where indicated.

Please attach itemized bills, receipts, and statements of charges from all physicians, hospitals and any other sources. These statements must contain the following:

- a. Patient's name.
- b. All service or supplies provided.
- c. The charge for each service or supply.
- d. The date each service or supply was provided.
- e. Diagnosis or illness involved.

Upon completion of the claim form, please submit along with the appropriate statements to:

First Administrators, Inc.
Claim Department
P.O. Box 9900
Sioux City, Iowa 51102

Toll Free (800) 206-0827
Local (712) 279-8400