Professional Benefit Administrators, Inc.

VISION CLAIM FORM

Send all bills to:
Professional Benefit Administrators, Inc.
P. O. Box 4687
Oak Brook, IL 60522-4687
800-435-5694

INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

- The claim form must be fully completed.
- Sign and date Part A on the back of the form if you wish to have benefits paid directly to the Provider of Service.
- Part B, should be completed by the Provider of Service unless you have itemized bills. (Bills must show the patient's name, the date and type of service, the charge, the diagnosis, and the social security number or Federal Tax I.D. number of the provider).
- Return the completed form to the address shown above with all the original copies of your bills.

Complete for all claims

Company Name:	Address:	
Employee name:	Date of birth:	ID#:
Home Address:		Phone:
Sex: ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed	
Spouses Name:	Date of birth:	ID#:
Is Spouse Employed? ☐ Yes ☐ No	If yes, Company Name:	
Address:		Phone:

Are you or your dependents entitled to benefits from any other Group Insurance Plan or Group Vision Plan? ☐ Yes ☐ No If yes, please identify:	A. Identify family member insured under other plan: B. Name(s) and address of their insurance company and/or organization C. Group Policy Number

Complete if claim is for dependent

Name:	Relationship:	Date of birth:
Home address if different from employee:		
Is dependent employed? ☐ Yes ☐ No	Name of Employer:	
Address:		Phone:

If claim is for child over 18 indicate:
A. **Student** ☐ Full-time ☐ High School ☐ Vocational ☐ College
Credit hours of study: _____ Name & Address of School: _____

B. **Handicapped**, Please Explain:_____

CERTIFICATION & AUTHORIZATION TO RELEASE INFORMATION : I certify that these statements and answers are true to the best of my knowledge and belief. I hereby agree to reimburse this plan to the extent that benefits are provided under any Workers' Compensation law, similar legislation, and/or any settlement related to such coverages.

I hereby authorize any insurance company, provider, or any other organization to release all information to PBA, Inc., which may have a bearing on the benefits payable under this plan. A photocopy of this authorization will be considered as effective and valid as the original, and will be valid for one year from the date below.

Date: _____ Signature of Employee: _____ Signature of Spouse: _____
(if claim is on spouse)

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE : I hereby authorize payment directly to the undersigned Provider of Service, the Vision Benefits, if any, otherwise payable to me, for the services as described but not to exceed the reasonable and customary charge for those services.

Part A – To be completed by the employee

Employee's Name:	ID Number:	Patient's Name if Dependent of Employee:
Employee's Address:		Phone:

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE : I hereby authorize payment directly to the undersigned Provider of Service, the Vision Benefits, if any, otherwise payable to me, for the services as described below but not to exceed the reasonable and customary charge for those services.

Signed(employee): Date:

Part B – to be completed by the provider of service

Diagnosis and concurrent conditions:	Date Service Began:
Did you prescribe: ☐ Yes ☐ No	Date Service Completed:

REPORT OF SERIVCES **(or attached itemized bill.)(if previous form submitted to PBA. You need show only date and services since last report.)**

Date of Services			**Charges**
	Prescribing		
	(a) Eye Examination	☐ With tonometry ☐ Without tonometry ☐ With visual fields ☐ Vision Survey	$
	(b) Prescribing Fee		$
	Dispensing Fee		
	(a) Lenses	☐ Single ☐ Bifocal ☐ Trifocal ☐ Lenticular ☐ Tinted ☐ Temper ☐ List Other – i.e. sunglasses_____	$
	(b) Frame	☐ New ☐ Old Frame	$
	Materials		
		☐ Lenses	$
		☐ Frames	$
		☐ Contacts	$
		☐ Other Materials or Services (List)	$

If Contact Lenses: ☐ Prescribed for a non-aphakic patient. ☐ In lieu of spectacles. ☐ Other, give reason:	Total Charges	$
	Amount Paid	$
	Balance Due	$

Does patient have other health coverage:

☐ Yes ☐ No If yes, please identify:

I do not accept assignment ☐ Yes ☐ No	Social Security No: OR Fed. ID No:

Date	Physician's Name (Print)	Signature	☐ Ophthalmologist ☐ Optometrist ☐ Optician

Address:	Phone: