CLAIM INSTRUCTIONS

EMPLOYEE:

- 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 copy of itemized receipts.
- Submit the form to:

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187
CLIFTON, NEW JERSEY 07015
TOLL FREE 800-672-7723

If you have any questions, please contact NVA at 800-672-7723.

CLAIM FOR VISION CARE EXPENSE
FOR NON-PARTICIPATING PROVIDERS

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
800-672-7723

EMPLOYEE Please Complete This Section *(Print)*

LAST NAME	FIRST	CARD MEMBER S.S. NO.
STREET ADDRESS		
CITY	STATE	ZIP

COMPLETE IF CLAIM FOR DEPENDENT

FIRST NAME	DATE OF BIRTH	SEX	STATUS
	/ /	❒ MALE ❒ FEMALE	❒ SPOUSE ❒ CHILD
SPONSOR NAME		MARITAL STATUS ❒ SINGLE ❒ MARRIED ❒ WIDOWED ❒ DIVORCED ❒ LEGALLY SEPARATED	

IMPORTANT. I 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, SPONSOR, POLICY HOLDER AND THE EMPLOYER.

EMPLOYEE SIGNATURE ______________________ DATE ______________

IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? ❒ YES ❒ NO 2) SAFETY GLASSES? ❒ YES ❒ NO 3) CATARACT SURGERY? ❒ YES ❒ NO. IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN SPACE PROVIDED.

IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? ❒ YES ❒ NO. IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN SPACE PROVIDED.

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST *(Print)*

EXAMINER NAME ❒ MD ❒ 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 GLASSES? ❒ YES ❒ NO	
CITY STATE ZIP	DID PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? ❒ YES ❒ NO	
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON. SIGNATURE ______ DATE ______	DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? ❒ YES ❒ NO IF YES: CHANGES: AXIS______ SPHERE OR CYLINDER ______	SERVICE CHARGE $

I HAVE PRESCRIBED ❒ SINGLE VISION ❒ BIFOCAL ❒ TRIFOCAL ❒ APHAKIC ❒ CONTACTS ❒ HARD ❒ SOFT ❒ COSMETIC ❒ MEDICALLY REQUIRED

TO BE COMPLETED BY DISPENSER *(Print)*

DISPENSER NAME	TAX ID#
STREET ADDRESS	
CITY STATE ZIP	

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.

SIGNATURE ______________ DATE ______________

PATIENT NAME	DATE OF SERVICE

Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD
RIGHT					
LEFT					

MATERIALS SUPPLIED	CHARGES	NVA USE
❒ SINGLE VISION		
❒ BIFOCAL		
❒ TRIFOCAL		
❒ APHAKIC		
❒ CONTACTS ❒ HARD ❒ SOFT		
❒ TINT #______ COLOR______		
❒ OTHER ______		
FRAME		
TOTAL CHARGE		

LENSES

U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE			
TRADE NAME	WIDTH	❒ PAIR ❒ GLASS	❒ ONE ❒ PLASTIC

FRAMES

MANUFACTURER	SIZE	MODEL OR STYLE
FRAME NUMBER	❒ PLASTIC ❒ COMBINATION ❒ METAL	❒ NEW ❒ PATIENTS

COUNCIL 90 AFSCME UNION LABEL