



VISION CLAIM

SEND CLAIMS DIRECTLY TO:

MedBen
P.O. Box 1099 • 1975 Tamarack Road • Newark, Ohio 43058-1099
(740) 522-8425 • Toll-Free (800) 423-3151

PART I — TO BE COMPLETED AND SIGNED BY PATIENT

PARTICIPANT'S NAME (LAST, FIRST, MIDDLE INITIAL)		SOCIAL SECURITY NUMBER	PARTICIPANT'S BIRTHDATE
PARTICIPANT'S HOME ADDRESS		CITY/STATE/ZIP CODE	PHONE (AREA CODE)
GROUP NAME		FOR WHICH BENEFIT(S) IS/ARE THE PATIENT NOW ELIGIBLE? <input type="checkbox"/> EXAM <input type="checkbox"/> LENSES <input type="checkbox"/> FRAME	
PATIENT'S NAME (IF OTHER THAN EMPLOYEE)		<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE PATIENT'S BIRTH DATE / /	IF CHILD'S AGE IS 19-24: FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO
ARE YOU OR YOUR DEPENDENTS ENTITLED TO VISION BENEFITS UNDER ANY OTHER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FROM WHOM?			
IS VISION CARE REQUIRED BECAUSE OF AN INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES: DATE OF THE INJURY? / / INJURY HAPPEN AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO			
RELEASE OF INFORMATION - PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits, and (4) any employer to provide the Medical Benefits Companies or their legal representative any information in their possession which is relevant to this claim or to the specific treatment or condition(s) for which I am being treated. This information will be used to determine the benefits payable and will be utilized by employees and agents of Medical Benefits Companies with responsibility for review and payment of claims. I hereby authorize any provider of health care services, claim administrators, insurers, reinsurers, stop loss carriers and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about the health status of, and health care services provided to, the patient. This authorization is effective on the date signed and shall remain in effect for the term of my coverage under the plan of benefits administered by Medical Benefits Companies. (You or any individual authorized by law to act on your behalf have a right to receive a copy of this authorization). A photographic copy of this authorization shall be as valid as the original.			
			PATIENT OR AUTHORIZED PERSON'S SIGNATURE - DATE
AUTHORIZATION OF PAYMENT — I authorize the payor at its option to issue payment to the provider(s) indicated on this claim.			
			PATIENT OR AUTHORIZED PERSON'S SIGNATURE - DATE

PART II — TO BE COMPLETED BY DOCTOR

DATE OF EXAM / /	REFRACTION <input type="checkbox"/> YES <input type="checkbox"/> NO TONOMETRY <input type="checkbox"/> YES <input type="checkbox"/> NO	HAD CATARACT SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> NO	CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO	MUST BE COMPLETED IF THERE WAS A PRIOR PRESCRIPTION: 1. AXIS CHANGE: DEGREES 2. SPHERE OR CYLINDER CHANGE: DIOPTERS							
DO NEW LENSES IMPROVE VISUAL ACUITY BY AT LEAST ONE LINE ON THE STANDARD CHART? <input type="checkbox"/> YES <input type="checkbox"/> NO								
	SPHERE	CYL	AXIS	PRISM	BASE	ADD	<input type="checkbox"/> SINGLE VISION	<input type="checkbox"/> BIFOCAL
OD							<input type="checkbox"/> TRIFOCAL	<input type="checkbox"/> LENTICULAR
OS							<input type="checkbox"/> CONTACT	
DIAGNOSIS OR SPECIAL INSTRUCTIONS:							UCR EXAMINATION CHARGE: \$ REQUIRED CO-PAY BY PATIENT: \$	
DOCTOR'S NAME/DEGREE				ADDRESS				
SIGNATURE				DATE		PHONE (AREA CODE) S.S. # OR EMP. I.D.		

PART III — TO BE COMPLETED BY DISPENSER

DATE ORDERED	STANDARD MATERIALS/SUPPLIES WITHOUT EXTRA CHARGE <input type="checkbox"/> SV (INCLUDES OVERSIZE) <input type="checkbox"/> LENT <input type="checkbox"/> GLASS <input type="checkbox"/> BI: STYLE/WIDTH = <input type="checkbox"/> PINK #1 OR #2 <input type="checkbox"/> TRI: STYLE/WIDTH = <input type="checkbox"/> PLASTIC	UCR LENS CHG. \$:	<input type="checkbox"/> FRAME (ENTER RETAIL COST BELOW)
EXTRA CHARGE ITEM:			CHARGE TO PATIENT:
<input type="checkbox"/> MULTIFOCAL EXTRA: <input type="checkbox"/> EXECUTIVE <input type="checkbox"/> PROGRESSIVE INVISIBLE <input type="checkbox"/> OTHER _____			= (1) _____
<input type="checkbox"/> OVERSIZE LENS CHARGE (MULTIFOCAL ONLY)			= (2) _____
<input type="checkbox"/> TINT CHARGE OTHER THAN PINK #1 OR #2 <input type="checkbox"/> GRADIENT CHARGE			= (3) _____
<input type="checkbox"/> PHOTOCROMIC			= (4) _____
<input type="checkbox"/> OTHER (PLEASE EXPLAIN)			= (5) _____
<input type="checkbox"/> RETAIL COST OF FRAME SUPPLIED \$ _____ MINUS FRAME RETAIL ALLOWANCE: \$ _____			= (6) _____
TOTAL EXTRA CHARGE (ADD LINES 1-6 AND INCLUDE TAX)			= (7) _____
REQUIRED PATIENT LENS CO-PAY (IF ANY)			= (8) _____
TOTAL PATIENT OUT-OF-POCKET COST (ADD LINES 7 AND 8)			= _____
FRAME NAME/MANUFACTURER		LENS FABRICATING LAB	
DISPENSER'S NAME		ADDRESS	
SIGNATURE		PHONE (AREA CODE) S.S. # OR EMP. I.D.	

WARNING: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER OR HEALTH BENEFIT PLAN, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE OR HEALTH CARE FRAUD UNDER STATE AND/OR FEDERAL LAW.

INSTRUCTIONS FOR FILING YOUR MEDBEN CLAIM

Please take time to familiarize yourself with these instructions. Proper completion of the form by you will prevent unnecessary delays in processing your claim. All incomplete claim forms will be returned.

1. Complete the top section indicated on the left margin as Part I.
2. Please submit a separate claim form for each patient.
3. Keep a copy of the bills for your record. This can prevent you from inadvertently filing duplicate claims.
4. If you are also covered by another insurer, Blue Cross/Blue Shield plan, HMO, Medicare, or other governmental agency, please be sure to attach a copy of that Company's Explanation of Benefits to this claim. Check the Explanation of Benefits form to be sure that it is for the same date(s) of service, provider, and charges that you are submitting on this claim.

INSTRUCTIONS FOR DIRECT MAILING: Turn statement over to the front side, fold twice like a letter (top folds down, bottom folds up). The mailing address should appear on one side and a blank panel on the other side. Tape the form closed at bottom center of mailing address side, affix proper postage and mail. If sending more than one statement, use an envelope.

Medical Benefits Administrators, Inc.
P.O. Box 1099, 1975 Tamarack Road
Newark, Ohio 43058-1099

Put Stamp Here.
The Post Office
will not deliver
mail without
proper postage.
