MedBen
health. benefits.

VISION CLAIM

SEND CLAIMS DIRECTLY TO:

MedBen • P.O. Box 1099 • Newark, Ohio 43058-1099
(740) 522-8425 • Toll-Free: (800) 423-3151
Fax: (740) 522-5002 • E-mail: providerclaimsfax@medben.com

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?
	☐ EXAM ☐ LENSES ☐ FRAME

PATIENT'S NAME (IF OTHER THAN EMPLOYEE)	☐ SPOUSE ☐ CHILD ☐ MALE ☐ FEMALE PATIENT'S BIRTH DATE	IF CHILD'S AGE IS 19-24: FULL-TIME STUDENT? ☐ YES ☐ NO DISABLED? ☐ YES ☐ NO

ARE YOU OR YOUR DEPENDENTS ENTITLED TO VISION BENEFITS UNDER ANY OTHER PLAN? ☐ YES ☐ NO IF YES, FROM WHOM?

IS VISION CARE REQUIRED BECAUSE OF AN INJURY? ☐ YES ☐ NO IF YES: DATE OFTHE INJURY? INJURY HAPPEN AT WORK? ☐ YES ☐ 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 ☐ YES ☐ NO TONOMETRY ☐ YES ☐ NO	HAD CATARACT SURGERY? ☐ YES ☐ NO	CAN VISUAL ACUITY BE RESTORED TO AT LEASE 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? ☐ YES ☐ NO

DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? ☐ YES ☐ 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? ☐ YES ☐ NO

	SPHERE	CYL	AXIS	PRISM	BASE	ADD
OD						
OS						

☐ SINGLE VISION ☐ BIFOCAL
☐ TRIFOCAL ☐ LENTICULAR
☐ 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	SV (INCLUDES OVERSIZE) | LENT BI: STYLE/WIDTH = | PINK #1 OR #2 TRI: STYLE/WIDTH = | PLASTIC	UCR LENS CHG. $:	☐ FRAME (ENTER RETAIL COST BELOW)

EXTRA CHARGE ITEM: **CHARGE TO PATIENT:**

☐ MULTIFOCAL EXTRA: ☐ EXECUTIVE ☐ PROGRESSIVE INVISIBLE OTHER_____ = (1) _____

☐ OVERSIZE LENS CHARGE (MULTIFOCAL ONLY) = (2) _____

☐ TINT CHARGE OTHER THAN PINK #1 OR #2 GRADIENT CHARGE = (3) _____

☐ PHOTOCHROMIC = (4) _____

☐ OTHER (PLEASE EXPLAIN) = (5) _____

☐ 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 DISPENSER'S NAME	LENS FABRICATING LAB ADDRESS
SIGNATURE DATE	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.