



NATIONAL VISION ADMINISTRATORS
P.O. Box 2187 / Clifton, N.J. 07015



**MEMBER INQUIRIES
CUSTOMER SERVICE
800-672-7723**

CLAIM FOR VISION CARE EXPENSE

EMPLOYEE - Please Complete This Section (Print)

LAST NAME	FIRST	EMPLOYEE S.S. NO.							
STREET ADDRESS		FIRST NAME	DATE OF BIRTH	SEX	STATUS				
			/ /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD				
CITY	STATE	ZIP	MARITAL STATUS						
		<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED							

ARE YOU, YOUR SPOUSE OR DEPENDENTS COVERED UNDER ANY OTHER VISION PLAN? NO YES: PLAN _____

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.

YES NO
EMPLOYEE SIGNATURE _____ DATE _____

TO BE COMPLETED BY EXAMINER	TO BE COMPLETED BY DISPENSER
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PATIENT NAME	DATE OF EXAM	PATIENT NAME	DATE OF SERVICE
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IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? <input type="checkbox"/> YES <input type="checkbox"/> NO. 2) SAFETY GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO. 3) CATARACT SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN SPACE PROVIDED.	MATERIALS SUPPLIED	CHARGES	NVA USE
	<input type="checkbox"/> SINGLE VISION		
	<input type="checkbox"/> BIFOCAL		
	<input type="checkbox"/> TRIFOCAL		

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	<input type="checkbox"/> APHAKIC		
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DID PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CONTACTS <input type="checkbox"/> HARD <input type="checkbox"/> SOFT		
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DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES: CHANGES:	<input type="checkbox"/> TINT # _____ COLOR _____		
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SERVICE CHARGE AXIS _____ SPHERE OR CYLINDER _____ \$	<input type="checkbox"/> OTHER _____		
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I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON. SIGNATURE _____ DATE _____	FRAME		
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I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON. SIGNATURE _____ DATE _____	TOTAL CHARGE		
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I HAVE PRESCRIBED <input type="checkbox"/> SINGLE VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> APHAKIC <input type="checkbox"/> CONTACTS <input type="checkbox"/> HARD <input type="checkbox"/> SOFT <input type="checkbox"/> COSMETIC <input type="checkbox"/> MEDICALLY REQUIRED	I HEREBY CERTIFY THAT I HAVE RENDERED SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON. SIGNATURE _____ DATE _____		
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RX SPHERE CYLINDER AXIS PRISM ADD						L E N S E F R A M E S	U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE					
RIGHT							TRADE NAME WIDTH <input type="checkbox"/> PAIR <input type="checkbox"/> ONE <input type="checkbox"/> GLASS <input type="checkbox"/> PLASTIC					
LEFT							MANUFACTURER SIZE MODEL OR STYLE					
							FRAME NUMBER <input type="checkbox"/> PLASTIC <input type="checkbox"/> COMBINATION <input type="checkbox"/> NEW <input type="checkbox"/> METAL <input type="checkbox"/> PATIENTS					

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.
- Claim must be received by National Vision Administrators within 12 months of the date of service.
- 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.