

CLAIM FORM ~ OPTICAL EXPENSE

GROUP INSURANCE

Note: Submit claims to & verify coverage with
C. B. TRACY & ASSOCIATES, INC

506 Pellis Road
 Greensburg, PA 15601
 Phone: 724-834-1090; 800-838-1090
 Fax: 724-834-1070

TO BE COMPLETED BY EMPLOYEE (INSURED PERSON)

| | | | | | |
|--|--|--|---------------|--|--|
| Name of Patient | S.S.# | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth | Is Patient <input type="checkbox"/> Yourself <input type="checkbox"/> Your Spouse <input type="checkbox"/> Your Child | Is Patient <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated |
| Name of Employee | S.S.# | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth | | |
| Employer | | | | | |
| First Name of Employee's Spouse | | If patient is child, is Child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Is Employee's Spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If "Yes," give complete name & mailing address of Child's Employer | | | |
| If "yes," give complete name and mailing address of Spouse's Employer | | Is Child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Is this Claim the result of Accidental Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Occupational Injury <input type="checkbox"/> Yes <input type="checkbox"/> No | | If "Yes," Name of School | | | |
| Is Patient covered through any other plan which provides benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If "yes," what other insurance company or service plan is providing this coverage? | | | | | |
| Name | Identify type of other coverage (Single, Family, etc.) | | | | |
| Address | Medical | | | | |
| City | Dental | | | | |
| State | Vision | | | | |
| Zip | Drug | | | | |
| I certify that the foregoing statements and answers are true and complete to the best of my knowledge and belief. I understand that some states require that I be notified that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I hereby authorize any insurance company, pre-payment organization, employer, union, trust fund, hospital, physician or dentist to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization shall be considered as effective and valid as the original. Please note that the signatures that are required on the other side of this form may not be copied. | | | | | |
| Date | Signature of Employee | | | | |
| | X | | | | |
| Home Address | Street | City | State | Zip Code | Phone No. |

► **Non-completion of any of the above questions could result in a delay in processing of your claim** ◀

TO BE COMPLETED BY C. B. TRACY and ASSOCIATES, INC.

| | | |
|--|---|---|
| Name of Company or Plan | Patient's Coverage If coverage terminated, show termination date If coverage reinstated, show date reinstated | Month Day Year |
| Social Security No. | Group Policy No. | Effective Date |
| Is Employee entitled to Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Has he made claim for such benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date | Employer or Plan Administrator | Claims Examiner |
| Remarks | | |

SEE REVERSE SIDE FOR STATEMENT TO BE COMPLETED BY PROVIDER OF SERVICE ⇨

NOTE: IF PAYMENT IS TO BE SENT TO THE PROVIDER, PLEASE SIGN ON BACK, LOWER RIGHT CORNER.

C. B. TRACY & ASSOCIATES, INC.

OPTICAL EXPENSE CLAIM ~ STATEMENT OF PROVIDER OF SERVICE

| | |
|----------------------------|---------------|
| Patient's name and address | Date of Birth |
|----------------------------|---------------|

Diagnosis or description of vision problem

Is treatment the result of an accident? Yes No
 Did condition arise out of patient's employment? Yes No

Are any of the services for the first pair of glasses or contacts following cataract surgery? Yes No
 If yes, state date of surgery

To be completed for no-line or progressive type spectacle lenses
 Were trifocal lenses medically necessary or would patient have received bifocal lenses if flat top lenses had been issued?
 Bifocals Trifocals

To be completed for Contact Lenses
 Were contact lenses prescribed for severe corneal astigmatism, severe scarring, keratoconus or aphakia? Yes No
 Can visual acuity be improved up to at least the 20/40 level by contact lenses? Yes No
 Could visual acuity be improved up to at least 20/40 level by spectacle lenses? Yes No
 Are they disposable lenses? Yes No

| Check all appropriate Boxes below | Check Appropriate Box | | Description of Service <small>List services, materials, and fittings separately, including fees</small> | Date of Service | Fee |
|---|-----------------------|---------|--|-----------------|-----|
| <input type="checkbox"/> Exam | Lt. Eye | Rt. Eye | | | |
| <input type="checkbox"/> Refraction | | | | | |
| <input type="checkbox"/> Single Vision | | | | | |
| <input type="checkbox"/> Bifocal | | | | | |
| <input type="checkbox"/> Double Bifocal | | | | | |
| <input type="checkbox"/> Trifocal | | | | | |
| <input type="checkbox"/> Progressive | | | | | |
| <input type="checkbox"/> Aphakic | | | | | |
| <input type="checkbox"/> Plastic | | | | | |
| <input type="checkbox"/> Glass | | | | | |
| <input type="checkbox"/> Case Hardened | | | | | |
| <input type="checkbox"/> Contacts | | | | | |
| Total Charges \$ | | | | | |

| | | |
|--|-----------|----------------|
| Name of provider of Service (please print) | Phone No. | License Number |
|--|-----------|----------------|

Address

| | | |
|---|--|---|
| I certify that, within the scope of my licensure, <input type="checkbox"/> I performed the services listed above <input type="checkbox"/> I prescribed the materials listed above <input type="checkbox"/> I provided the materials listed above *** Signature of provider of service (signature may not be photocopied) Date _____ | I.R.S. Identification No. (Social Security or Employer Number) _____ <small>Must be furnished under Authority of Law</small> <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist <input type="checkbox"/> Optician | AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE: <i>I hereby authorize payment directly to the undersigned provider of service of the group insurance benefits otherwise payable to me, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.</i> X _____ Signature of insured person ONLY IF PAYMENT IS TO BE SENT DIRECTLY TO THE PROVIDER Date _____ |
|---|--|---|

*** Some states require that you be notified that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.