

Vision Claim Form



MERITAINSM
HEALTH

An Aetna Company

Complete and send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057

For ALL claims, this area must be filled in completely.

Employee Information				
Employee's Name (last, first, middle initial)			Employee ID Number	
Address			Employee's Date of Birth	
City	State	Zip Code	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	

If the patient is a dependent, please complete ALL of the following. If the patient is the employee, go directly to the area below the shaded box.

Patient Information				
Patient's Name (if other than employee)			Patient's ID Number	
Patient's Date of Birth (Month, Day, Year)			Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	If child, is (s)he married? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient covered by another Employer Group Plan or Retirement Group Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete the two items below)				
Name of Employer	Group Number	Name and address of Insurance Company or Organization		
Release				
Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud, submits an application for coverages, or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Criminal and/or Civil penalties can result from such acts.				
I hereby authorize payment of these benefits be send directly to: <input type="checkbox"/> Provider of Service <input type="checkbox"/> Employee (attach itemized bill or receipt)				
Patient's Signature (parent or guardian if claim is on a minor)			Date	

The below sections are to be completed by the Provider.

Exam				
Indicate the nature of disease, injury or vision disorder			Date of examination	Name of provider performing services
Refraction? Yes <input type="checkbox"/> No <input type="checkbox"/> Contact Lenses? Yes <input type="checkbox"/> No <input type="checkbox"/> Tonometry? Yes <input type="checkbox"/> No <input type="checkbox"/> Cataract Surgery? Yes <input type="checkbox"/> No <input type="checkbox"/>			Address	
Examination Charge: \$			City	
Amount paid by employee: \$			State	Zip Code
Signature of provider		Degree/Title	Date	Provider's Social Security or Tax ID Number (required by law):

Lenses					Frames					
Date ordered:		Date dispensed:		<input type="checkbox"/> Pair <input type="checkbox"/> 1/2 Pair		Date ordered		Date dispensed		Parts <input type="checkbox"/> Complete <input type="checkbox"/> Partial
OD	Sphere	Cylinder	Axis	Prism	Add	Frame Charge \$			Name of provider performing services (please print)	
OS										
Type Lens:				Charge		Address		City, State, Zip		
<input type="checkbox"/> Single vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular										
<input type="checkbox"/> Contact Lenses						Provider's Social Security Number or Tax ID Number				
<input type="checkbox"/> Oversized Lenses										
<input type="checkbox"/> Sunglasses						Signature of provider		Degree/Title		Date
<input type="checkbox"/> Tint #										
<input type="checkbox"/> Photosensitive – i.e. Brown, Gray, etc.						Total Charge: \$ Amount paid by employee: \$				
<input type="checkbox"/> Other										
Lens Manufacturer:										
Lens Charge \$										

IMPORTANT: CLAIMS CANNOT BE PAID UNTIL THE CLAIM FORM IS PROPERLY COMPLETED AND RECEIVED. Do not send this form through your employer. ATTACH PROVIDER BILLING. If you require assistance in presenting this claim, call your Service Delivery Team at the number listed on your member ID Card.