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.
- 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.

CLAIM FOR VISION CARE EXPENSE
FOR NON-PARTICIPATING PROVIDERS

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
800-672-7723

EMPLOYEE Please Complete This Section *(Print)*

LAST NAME | FIRST | CARD MEMBER S.S. NO. ___-___-____

STREET ADDRESS

CITY | STATE | ZIP

COMPLETE IF CLAIM FOR DEPENDENT

FIRST NAME	DATE OF BIRTH	SEX	STATUS
	/ /	☐ MALE ☐ FEMALE	☐ SPOUSE ☐ CHILD

SPONSOR NAME

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ WIDOWED
☐ DIVORCED ☐ LEGALLY SEPARATED

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.

EMPLOYEE SIGNATURE _____ DATE _____

IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? ☐ YES ☐ NO 2) SAFETY GLASSES? ☐ YES ☐ NO 3) CATARACT SURGERY? ☐ YES ☐ NO. IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN SPACE PROVIDED.

IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? ☐ YES ☐ NO. IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN SPACE PROVIDED.

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST *(Print)*

EXAMINER NAME | ☐ MD ☐ OD | TAX ID#

STREET ADDRESS

CITY | STATE | ZIP

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.

SIGNATURE _____ DATE _____

PATIENT NAME | DATE OF EXAM

CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? ☐ YES ☐ NO

DID PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? ☐ YES ☐ NO

DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? ☐ YES ☐ NO IF YES: CHANGES:

AXIS _____ SPHERE OR CYLINDER _____

SERVICE CHARGE
$

I HAVE PRESCRIBED ☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ APHAKIC ☐ CONTACTS ☐ HARD ☐ SOFT ☐ COSMETIC ☐ MEDICALLY REQUIRED

TO BE COMPLETED BY DISPENSER *(Print)*

DISPENSER NAME | TAX ID#

STREET ADDRESS

CITY | STATE | ZIP

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.

SIGNATURE _____ DATE _____

PATIENT NAME | DATE OF SERVICE

Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD
RIGHT					
LEFT					

MATERIALS SUPPLIED	CHARGES	NVA USE
☐ SINGLE VISION		
☐ BIFOCAL		
☐ TRIFOCAL		
☐ APHAKIC		
☐ CONTACTS ☐ HARD ☐ SOFT		
☐ TINT #_____ COLOR_____		
☐ OTHER _____		
FRAME		
TOTAL CHARGE		

LENSES: U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE

TRADE NAME | WIDTH | ☐ PAIR ☐ ONE ☐ GLASS ☐ PLASTIC

FRAMES: MANUFACTURER | SIZE | MODEL OR STYLE

FRAME NUMBER | ☐ PLASTIC ☐ COMBINATION ☐ METAL | ☐ NEW ☐ PATIENTS

INDIVIDUAL APPLICATION/CHANGE FORM

FOR VISION COVERAGE

(Please Print or Type)

EMPLOYER (GROUP) NAME	GROUP NO.
NECA Local Union No. 313 IBEW Health & Welfare Fund	**1233 0000**

EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	GENDER	CONTRACT TYPE REQUESTED
— —	☐ Male ☐ Female	☐ Single ☐ Employee + 1 (Limited) ☐ Employee + 2 (Limited) ☐ Family

EFFECTIVE DATE OF COVERAGE *OR* CHANGE	DATE OF HIRE

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES

THIS CHANGE IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT(S)

TYPE OF CHANGE: ☐ NEW ENROLLMENT ☐ CHANGE OF ADDRESS ☐ NAME CHANGE ☐ REINSTATEMENT

☐ ISSUE CARD ☐ CANCEL COVERAGE ☐ NAME CHANGE, FORMERLY _____

LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	STUDENT (Y/N)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: X _____ DATE: _____

EMPLOYER SIGNATURE: X _____ DATE: _____