# Vision Claim Form

*Please clearly **PRINT** all information*

**File a Claim by Mail:**
Nova Healthcare Administrators
P. O. Box 211428, Eagan, MN 55121
**Fax:** (716) 932-5098

| | |
|---|---|
| Employer:<br>Group #: | IF A FLEX PLAN APPLIES, DO YOU WANT TO APPLY unreimbursed expenses to your flexible spending account? ☐ Yes ☐ No |
| PATIENT INFORMATION | 1. Date of Last Eye Exam: Mo. Day Yr. |
| 2. Patient Name (Last, First, Middle) | 3. Policy holder/Subscriber ID |
| 4. Employee's Name (Last, First, Middle) | 5. Patient's Birthdate: Mo. Day Yr. |
| 6. Address, City, State, Zip | 7. ☐ Male ☐ Female<br>8. Relationship of Patient to Employee<br>1. ☐ Self 2. ☐ Spouse 3. ☐ Child 4. ☐ Other |
| 11. I hereby certify that replacement was not made as a result of lost, broken, damaged or stolen lenses, contact lenses or frames.<br>_____<br>Patient Signature *(or parent if minor)* Date | 9. Does patient have other vision insurance?<br>☐ Yes ☐ No<br>10. Service related to: Auto Accident ☐ Yes ☐ No Employment Accident ☐ Yes ☐ No |

OPTOMETRIST INFORMATION

| | |
|---|---|
| 12. Provider's Name & Mailing Address | 13. Eye Exam and Refraction<br>Date of Exam: Mo. Day Yr.<br>Charge: $_____ |
| 14. Provider's Tax ID:<br>Provider's Phone #: | 15. Prescription<br>Right Eye: _____<br>Left Eye: _____ |

16. ASSIGNMENT – IF YOU WISH BENEFITS PAID DIRECTLY TO YOUR PROVIDER OF SERVICES, PLEASE SIGN BELOW.
I hereby authorize payment directly to the above-named provider of the Vision Plan Benefits herein specified and otherwise payable to me but not to exceed the benefits provided by the plan. I hereby agree than any payment made in accordance with this authorization shall constitute a complete release of the Plan of all liability to the extent of such payment and that I am financially responsible for charges not covered by this authorization. understand I am financially responsible for charges not covered by this assignment.

Patient Signature *(or parent if minor)*: _____ Date: _____

SUPPLIER INFORMATION

| | |
|---|---|
| 17. Supplier's Name & Mailing Address | 18. Supplier's Tax ID:<br>Supplier's Phone #:<br>19. Supplies Cost:<br>Frame: $_____ Lenses: $_____ Contacts: $_____ |

22. ASSIGNMENT – IF YOU WISH BENEFITS PAID DIRECTLY TO YOUR PROVIDER OF SERVICES, PLEASE SIGN BELOW.
I hereby authorize payment directly to the above-named provider of the Vision Plan Benefits herein specified and otherwise payable to me but not to exceed the benefits provided by the plan. I hereby agree than any payment made in accordance with this authorization shall constitute a complete release of the Plan of all liability to the extent of such payment and that I am financially responsible for charges not covered by this authorization. understand I am financially responsible for charges not covered by this assignment.

Patient Signature *(or parent if minor)*: _____ Date: _____

RELEASE OF INFORMATION - I hereby authorize any provider of service (hospital, physician or other person who has attended me, including insurance companies or other organizations), to furnish Nova Healthcare Administrators, Inc. or its authorized representatives, any and all information with respect to any illness or injury, medical history, consultation, prescription, treatment or predetermination of services, including a copy of any or all hospital or medical records or plan. A photocopy of this authorization shall be considered as effective and valid as the original. I further certify that the information furnished by me in support of this claim is true and correct.

Patient Signature *(or parent if minor)*: _____ Date: _____

*Questions? Please call Nova's Customer Service department using the phone number on your ID Card.*