Excellus

165 Court Street
Rochester, NY 14647

A nonprofit independent licensee of the
Blue Cross Blue Shield Association

# Vision Care

**Mail Completed Claims To:** **PO Box 21146**
**Eagan, MN 55121**

*Do Not Complete Shaded Areas*

| | | | | |
|---|---|---|---|---|
| Subscriber's Name | | Vision Policy ID# | Medicare no. | Medicare ☐ Yes ☐ No |
| Patient's Name | Sex ☐M ☐F | Motor vehicle accident ☐ Yes ☐ No | Accident injury date | Workers Comp ☐ Yes ☐ No |
| Patient's Birthdate | Relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Handicapped | Pay code | Does patient have other eye care Insurance? ☐ Yes ☐ No If yes, give name and address of other insurance co. | |
| Street | | | | |
| City, State, Zip | | | Other Insurance Contract/ID no. | Subscriber's name |
| Signature of subscribing member | Date | | PROVIDER NAME & ADDRESS | |
| Diagnosis *(if claim is for contact lenses)* | | | | |
| Referring physician or provider | | | Name of any other physician or provider rendering care | |

| Check Appr. Box | | Date of Service | | Service or Supplies | Proc Code | Charge | Reasonable Charge | Deductible |
|---|---|---|---|---|---|---|---|---|
| ☐ | 3 | | M | Eye Examination | | | | |
| ☐ | 3 | | M | Referral Eye Examination | | | | |
| ☐ | 3 | | M | Frames | | | | |
| ☐ | 3 | | M | Single Vision Lenses *(per pair)* | | | | |
| ☐ | 3 | | M | Bifocal Lenses *(per pair)* | | | | |
| ☐ | 3 | | M | Trifocal Lenses *(per pair)* | | | | |
| ☐ | 3 | | M | Lenticular Lenses *(per pair)* | | | | |
| ☐ | 3 | | M | Contact Lenses *(medically necessary)* | | | | |
| ☐ | 3 | | M | Contact Lenses *(cosmetic)* | | | | |
| ☐ | 3 | | M | Other | | | | |

A. Were contact lenses prescribed as necessary after cateract surgery? ☐ Yes ☐ No
B. Was vision in the worse eye correctable up to 20/40 or better? ☐ Yes ☐ No
C. If B above is no, will contact lenses correct vision in the worse eye to 20/40 or better? ☐ Yes ☐ No
A,B,C must be verified (attach form from your physician or optometrist)

***If this claim is being completed by a subscriber, please attach an itemized bill from the physician or provider.***

**Claim Date and Contract Holder Signature:** *(Unsigned claims will be returned.)*

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation. In addition, I hereby authorize any insurance company, organization, employer, hospital, doctor or any other provider of service to release any information relevant to this claim and any attached bills.

Date: / / Subscriber's Signature:

I certify that I am not an intern or resident and that this is a true and correct statement for services which were personally rendered by me as an attending physician/provider.

| PHYSICIAN/PROVIDER'S PERSONAL SIGNATURE | DATE |
|---|---|
| | |

RECEIVED
By A11y Updated at 10:42 am, Mar 23, 2018