HealthSmart

Vision Benefits Claim Form

Please mail completed form to:

HealthSmart Benefit Solutions ■ P.O. Box 91608 ■ Lubbock, TX 79490

Patient's And Insured (Subscriber) Information

Patient's Name (First, Initial, Last)

Patient's Date of Birth (MM/DD/YYYY)

Insured's Name (First, Initial, Last)

Patient's Address (Street, City, State, ZIP)

Patient's Sex
○ Male ○ Female

Insured's ID No. or Medicare No. (Include any letters)

Patient's Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured's Group Number or Group Name

Other Health Insurance Coverage — Enter name of policyholder, plan name and address, and policy or medical assistance number.

Was condition related to patient's employment? ○ Yes ○ No

Insured's Address (Street, City, State, ZIP)

Was condition related to an auto accident? ○ Yes ○ No

Insured's Telephone/Contact Number

Patient's Or Authorized Person's Signature

I authorize the release of any medical information necessary to process this claim and request payment of Medicare CHAMPUS benefits either to me or to the party who accepts assignment below.

I authorize payment of medical benefits to undersigned physician or supplier for services described below.

Signature

Date

Signature-Insured or Authorized Person

Physician's Or Supplier Information

Did visual analysis indicate a change in prescription from the preceding prescription?
○ Yes ○ No

Charges

Exam (Date of Service)

$

Lenses (Date of Service)

$

Type of Lenses (Indicate all that apply)

○ Single ○ Tinted
○ Bifocal ○ Sunglasses and/or safety glasses
○ Trifocal ○ Other

Frames (Date of Service)

$

Contacts (Date of Service)

$

Please advise reason for contacts
(Severe corneal astigmatism, severe corneal scarring, aphakia, patient prefers contacts, etc.)

Total Fee

$

Indicate the greatest degree of visual acuity improvement achieved by contact lenses

Amount Due

$

Indicate the greatest degree of visual acuity improvement achieved by glasses

Balance Due

$

Individual Practitioner's Social Security Number (Must be furnished under authority of law)

Other Employer Tax ID Number (Must be furnished under authority of law)

Date | Physician's Name | Signature | ○ Ophthalmologist ○ Optometrist ○ Optician | Telephone

Street Address | City | State | ZIP