

Please submit your billing along with this claim form to:

VISION CLAIM

BenefitSourceInc.

Claims Department
P.O. Box 240
Monroe, MI 48161-0240
(734) 242-4443 or
877-857-1453
Fax (734) 242-4437

- Pay me, if applicable (sign box 11 only)
- Pay Provider (sign both Box 11 & 12)

PATIENT & EMPLOYEE INFORMATION

1. PATIENT'S NAME (First Name, M.I., Last name)	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME (First name, M.I., Last name)
4. EMPLOYEE'S ADDRESS (Street, City, State, Zip code)	5. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	6. EMPLOYEE'S SOCIAL SECURITY NUMBER
	7. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. EMPLOYEE'S COMPANY NAME
9. OTHER VISION INSURANCE COVERAGE - Enter Name of Policyholder, Plan Name, Address and policy or Medical Assistance Number.	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY VISION INFORMATION NECESSARY TO PROCESS THIS CLAIM.	12. I AUTHORIZE PAYMENT OF VISION BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. SIGNED (Insured or Authorized Person)	

PHYSICIAN OR SUPPLIER INFORMATION

EXAM DATE OF SERVICE _____	CHARGES \$ _____
LENSES DATE OF SERVICE _____	\$ _____
TYPE OF LENSES <input type="checkbox"/> SINGLE <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL	WAS LENS <input type="checkbox"/> TINTED <input type="checkbox"/> SUNGLASSES AND/OR SAFETY GLASSES <input type="checkbox"/> OTHER _____
FRAMES DATE OF SERVICE _____	\$ _____
CONTACTS DATE OF SERVICE _____	\$ _____
PLEASE ADVISE REASON FOR CONTACTS (SEVERE CORNEAL ASTIGMATISM, SEVERE CORNEAL SCARRING, APHAKIA, OR PATIENT PREFERS CONTACTS, ETC.) _____	
INDIVIDUAL PRACTITIONER'S - SS# ALL OTHERS - EMPLOYER IRS# MUST BE FURNISHED UNDER AUTHORITY OF LAW	TOTAL FEE \$ _____ AMOUNT PAID \$ _____ BALANCE DUE \$ _____
DATE _____ PHYSICIAN'S NAME _____ SIGNATURE _____	<input type="checkbox"/> OPHTHALMOLOGIST <input type="checkbox"/> OPTOMETRIST <input type="checkbox"/> OPTICIAN TELEPHONE () -
STREET ADDRESS _____ CITY OR TOWN _____ STATE _____	ZIP CODE _____