



# VISION CLAIM FORM

BeniComp Inc.  
8310 Clinton Park Dr., Ft. Wayne. IN 46825

(260) 482-7400 ■ 1-800-837-7400

## EMPLOYER

<b>EMPLOYER</b>	Employee's Name (Please Print Full Name)			Employee's Social Security Number	<input type="text"/>
	Last	First	Middle Initial		
	Address			Marital Status:	
				<input type="checkbox"/> Single	<input type="checkbox"/> Married
				<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced
	City	State	Zip	Employee's Date of Birth	
				Month	Day
				Year	

<b>PATIENT</b>	Patient's Name (if other than employee)			Patient's Social Security Number	<input type="text"/>
	Last	First	Middle Initial		
	Patient's Date of Birth			Relationship to Employee	
	Month / Day / Year				
	Does Patient have other Vision Coverage?			If so, Other Insured's Name	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Other Insured's Name Policy or Group #			Was the accident connected with the Patient's employment?		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Auto Accident?			Other Accident?		
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			If Other accident, Explain		
			Insurance Plan Name or Program		

Description		Date	Charges	Co-Pays
Examination				
Contact Lens Examination				
Glaucoma Treatment				
Choose One of the Following: Pay Doctor		Pay Patient		
Could visual acuity be corrected to 20/70 in the better eye by use of conventional lenses?		Yes	No	
Have glasses or contacts been purchased?		Yes	No	
DIAGNOSIS:		Sphere	Cylinder	Axis
		R		Prism
		L		Base
		Add	Seg. HGT.	Seg. Woth
		R		Dist. P.D. Near
		L		
Prescription Change?				
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Description	Name of MFG.	Laboratory	Date of Service	Charges
Lenses				Discount
Single Vision				Co-payments
Bifocal				
Trifocal				
Lenticular				
Frames	Name	MFG.		
Contact Lenses	Cosmetics			
	20/70 Correction			
Extra	Itemize all additional Charges			
1 Tint	Type			
2 Oversize (Over 65 mm)				
3 Other				
4 Other				
5 Other				
Pay:	Doctor	Patient	Totals	
Provider's Name, Address, Tel #, Federal Tax I.D. #:			I hereby certify that the foregoing service/ materials have been completed/ delivered. The charges submitted are actual charges and intended to be collected. I understand any false claim, statements, or documents may be prosecuted under applicable Federal or State Laws.	
			Provider Signature: _____	

I certify that the above information is true and correct and the services listed have been delivered. I authorize any request information to be released to BeniComp Inc. and for the payment of allowable benefits to the provider.

Signature of Eligible Employee or Dependent

Date