Avēsis
A National Vision and Dental Company

VISION BENEFITS CLAIM FORM

PLEASE BE AS THOROUGH AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS FORM. ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

TO BE COMPLETED BY THE CARDHOLDER

1. PATIENT'S NAME *(Last, First, Middle)*		2. CARDHOLDER'S GROUP #	3. CARDHOLDER'S ID#
4. PATIENT'S BIRTH DATE	5. PATIENT'S SEX ☐ MALE ☐ FEMALE	6. RELATIONSHIP TO CARDHOLDER ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	7. CARDHOLDER'S NAME *(Last, First, Middle)*
8. CARDHOLDER'S ADDRESS (No., Street, City, State and Zip Code)			9. HOME NUMBER ( ) WORK NUMBER ( )
10. NAME OF INSURANCE CARRIER	11. NAME OF EMPLOYER	12. CARDHOLDER'S STATUS ☐ ACTIVE ☐ RETIRED ☐ HOURLY ☐ SALARIED	13. CARDHOLDER'S BIRTH DATE
14. PATIENT IS COVERED FOR VISION CARE BY ANOTHER PLAN ☐ YES ☐ NO IF YES, PLEASE COMPLETE BOXES 15 THROUGH 19		15. NAME AND ADDRESS OF THE OTHER CARRIER	
16. CARDHOLDER'S NAME	17. RELATIONSHIP TO CARDHOLDER ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	18. CARDHOLDER'S DATE OF BIRTH	19. CARDHOLDER'S S.S. #/GROUP#
20. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO AVESIS THIRD PARTY ADMINISTRATORS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION PROVIDED BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.			

SIGNATURE OF CARDHOLDER _____ DATE SIGNED _____

PLEASE CHECK ALL ITEMS BELOW THAT APPLY TO THE SERVICES RENDERED BY YOUR EYE CARE PROVIDER

DATE OF SERVICE _____

- ☐ EXAM
- ☐ CONTACT LENS FITTING/EXAM
- ☐ CONTACT LENSES
- ☐ EYEGLASS LENSES
  - ☐ SINGLE VISION
  - ☐ BIFOCAL
  - ☐ TRIFOCAL
  - ☐ PROGRESSIVE (NO LINE BIFOCAL)
  - ☐ OTHER _____
- ☐ FRAME

PLEASE SUBMIT THIS FORM WITH YOUR ITEMIZED RECEIPT(S) TO THE FOLLOWING

Avesis Third Party Administrators, Inc.
Vision Claims Department
P.O. Box 7777
Phoenix, AZ 85011-7777

Should you have any questions or require further assistance, please call the Avesis Service Center toll free at (800) 828-9341.

REV. 4.16.07