WEA trust

# Essential Vision Plan Claim Form

*National Vision Administrators manages the Essential Vision Plan on behalf of the WEA Trust.*

## CLAIM INSTRUCTIONS

- Use this form to obtain reimbursement for services
- Part A to be completed by Employee
- Part B to be completed by your Eye Care Professional (Optional)
- Submit the form to: National Vision Administrators, L.L.C.
  P.O. Box 2187
  Clifton, New Jersey 07015

If you have questions, please contact NVA at (877) 262-7915.

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# Essential Vision Plan Claim Form

PRINT ALL INFORMATION

## PART A – TO BE COMPLETED BY EMPLOYEE

| 1. EMPLOYEE'S NAME (Last, First, Middle) | 2. EMPLOYEE'S ADDRESS (No., Street, State, and Zip Code) |
|---|---|
| 3. EMPLOYEE'S SOCIAL SECURITY NUMBER | 4. TELEPHONE NUMBER |
| 5. EMPLOYER NAME | 6. EMPLOYER ADDRESS (No., Street, State, and Zip Code) |

| 7. PATIENT'S NAME (Last, First, Middle) | 8. PATIENT'S RELATIONSHIP TO EMPLOYEE<br>☐ Self ☐ Child ☐ Student<br>☐ Spouse ☐ Handicapped ☐ Other _____ | 9. PATIENT'S SEX<br>☐ Male<br>☐ Female | 10. PATIENT'S DATE OF BIRTH |
|---|---|---|---|

| 11. IS PATIENT COVERED FOR VISION CARE BY ANOTHER PLAN?<br>☐ NO<br>☐ YES | VISION PLAN NAME | GROUP NO. | NAME AND ADDRESS OF CARRIER |
|---|---|---|---|

12.
Any person who knowingly and with intent to defraud any insurance company or other person; files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

## PART B – TO BE COMPLETED BY EYE CARE PROFESSIONAL (OPTIONAL)

| 1. DOCTOR'S NAME (Last, First, Middle) | 2. TAXPAYER IDENTIFICATION NO. | PROFESSIONAL SERVICES | AMOUNT |
|---|---|---|---|
| 3. DOCTOR'S ADDRESS (No., Street, City, State, and Zip Code) | | EYE EXAMINATION | |
| 4. PHONE NO. (and Area Code) | 5. TITLE ☐ M.D. ☐ D.O. ☐ O.D. / 6. EXAMINATION DATE(S) / 7. WAS CATARACT SURGERY PERFORMED? ☐ NO ☐ YES | CONTACT LENS EXAM (if any) | |
| 8. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSES? ☐ NO ☐ YES | 9. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? ☐ NO ☐ YES | | |
| 10. DIAGNOSTIC CODE(S) | | AMOUNT PAID BY PATIENT | |
| 11. INDICATE DIAGNOSIS OR NATURE OF DISEASE, INJURY, OR VISION DISORDER. CODE #'S INDICATE PROCEDURE | | 12. VISUAL ACUITY CORRECTED TO: | |

13.

DOCTOR'S PRESCRIPTION

| | Sphere | Cylinder | Axis | Prism | Base |
|---|---|---|---|---|---|
| R.E. | | ● | | | |
| L.E. | | ● | | | |
| READING ADD | | R.E. | + ● | L.E. | + ● |

14. I hereby certify that I have performed the services as indicated heron.

DOCTOR'S SIGNATURE _____ DATE _____

## PART C – TO BE COMPLETED BY DISPENSER

| 1. DISPENSER'S NAME (Last, First, Middle) | 2. TAXPAYER IDENTIFICATION NO. |
|---|---|
| 3. DISPENSER'S ADDRESS (No., Street, City, State, and Zip Code) | 4. PHONE NO. (and Area Code) |

5. PROFESSIONAL SERVICES:

| | DATES(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | Place of Service | Type of Service | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | DIAGNOSIS CODE | $ CHARGES | DAYS OR UNITS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | |

| 6. PATIENT'S ACCOUNT NO. | 7. TOTAL CHARGE $ | 8. AMOUNT PAID $ | 9. BALANCE DUE $ |
|---|---|---|---|

10. I hereby certify that I have performed the services as indicated hereon.

DISPENSER'S SIGNATURE _____ DATE _____