PO Box 21660
Eagan, MN 55121
Phone: 1-800-228-6080
Fax: 1-402-496-8199

VISION INSURANCE CLAIM FORM

CLAIMANT'S PROOF OF LOSS

Insured's Name:______________________ Date of Birth:__________ Policy No.:__________

Address:____
Street City State Zip Code

Social Security No.:______________________

Telephone #:______________________

PATIENT INFORMATION

Patient's Name:____
Last Name First Name

Patient's Relationship to Insured: ❐ Self ❐ Spouse ❐ Child ❐ Other

Sex: ❐ Male ❐ Female

Date of Birth:__________ Month/Day/Year

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE DIAGNOSIS TO PROCEDURE BELOW)

PLEASE SELECT THE APPROPRIATE DIAGNOSIS AND PROCEDURE CODE FOR USE IN SECTION BELOW.

*Place of Service Codes:
10 Inpatient Hospital
20 Outpatient Hospital
30 Provider's Office
40 Patient's Home/Supply House

Diagnosis:
1 V72.0 Routine Eye Examination
2 367.0 Hypermetropia (Far-sightedness)
3 367.1 Myopia (Near-sightedness)
4 367.2 Astigmatism
5 367.4 Presbyopia
6 Other (Please specify with valid ICD-9 Code)
____

Procedure Codes:
1 92002 Eye Examination (Intermediate, New Patient)
2 92004 Eye Examination (Comprehensive, New Patient)
3 92012 Eye Examination (Intermediate, Established Patient)
4 92014 Eye Examination (Comprehensive, Established Patient)
5 92015 Refraction
6 Eyeglasses
7 Contacts
8 Other (Please specify with valid CPT Code)
____

A	B	C	D		E	F	G	H
DATE(S) OF SERVICE MM DD YY	*PLACE OF SERVICE	TYPE OF SERVICE	MODIFIER	PROCEDURES, SERVICES, OR SUPPLIES CPT OR HCPCS CODE	DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	LEAVE BLANK

FEDERAL TAX I.D. NUMBER SSN ❐ EIN ❐	PATIENT'S ACCOUNT NO.	ACCEPT ASSIGNMENT? (for government claims) ❐ Yes ❐ No	TOTAL CHARGES $	AMOUNT PAID $	BALANCE DUE $
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS SIGNED DATE	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE # PIN # GRP #		

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above-named patient.

Subscriber Signature ______________________ Date ______________

over, please