CLAIM INSTRUCTIONS

- Use this form to obtain reimbursement for services.
- Complete the employee section of the form.
- Sign and date the form after checking for completeness.
- Attach a copy of itemized receipts.
- Submit the form to:

NATIONAL VISION ADMINISTRATORS PO BOX 2187 CLIFTON, NEW JERSEY 07015

If you have any questions, please contact Capital Blue Cross Vision at 800.905.4102

On behalf of Capital Blue Cross, National Vision Administrators, LLC (NVA®) provides the network and assists in the administration of network management services for the Capital Blue Cross Vision benefits program. NVA is an independent company.

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Capital Blue Cross Vision



CLAIM FOR VISION CARE EXPENSE FOR NON-PARTICIPATING PROVIDERS

NATIONAL VISION ADMINISTRATORS

PO BOX 2187 / CLIFTON, NEW JERSEY 07015

800.905.4102

		DILIVIPLOTEL	(FIIIIC)					
SUBSCRIBER INFORMATION			PATIENT INFORMATION					
FIRST NAME		SUBSCRIBER ID (SSN OR ID#)						
STREET ADDRESS		PATIENT LAST NAME		PATIENT FIRST NAME				
STATE	ZIP CODE	DATE C	DF BIRTH	GENDER	STATUS			
		1	/	MALE 🗖	SPOUSE 🔲 CHILD 🔲			
I HEREBY CERTIFY THAT THE PATIENT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FOR THE BENEFITS AND THAT I HAVE RECEIVED THE SERVICES DESCRIBED. I ALSO CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN ON THE JOB INJURY OR COVERED UNDER ANOTHER VISION PROGRAM. I FURTHER AUTHORIZE THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITER, POLICY HOLDER AND THE EMPLOYER.								
EMPLOYEE'S SIGNATURE			DATE					
IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? I YES IN NO 2) SAFETY GLASSES? I YES INO 3) CATARACT SURGERY? I YES I NO IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN THE SPACE PROVIDED.								
IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE SPACE PROVIDED.								
	FIRST NAME STATE S	CRIBER INFORMATION FIRST NAME STATE ZIP CODE NT INFORMATION ENTERED ON THIS FORM IS CORREC CERTIFY THAT THE SERVICES AND MATERIALS RECEIVE E THE RELEASE OF ALL INFORMATION ON THIS FORM Y WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE NO 3) CATARACT SURGERY? YES NO OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRES MBER IN THE SPACE PROVIDED. BE COMPLETED BY EXAMINING OPH	CRIBER INFORMATION FIRST NAME FIRST NAME SUBSCRIBER ID (SSN OR ID#) PATIENT I PATIENT I STATE ZIP CODE DATE C / NT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN O E THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITH Y WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER TH. NO 3) CATARACT SURGERY? Y WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER TH. NO 3) CATARACT SURGERY? Y WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER TH. NO 3) CATARACT SURGERY? OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? BE COMPLETED BY EXAMINING OPHTHALMOLOGIS	FIRST NAME SUBSCRIBER ID (SSN OR ID#) PATIENT LAST NAME PATIENT LAST NAME STATE ZIP CODE DATE OF BIRTH / / NT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FO CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN ON THE JOB INJURY OR OR E THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITER, POLICY HOLDER AN MUTH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY NO 3) CATARACT SURGERY? DATE	CRIBER INFORMATION PATIENT INFORMATION FIRST NAME SUBSCRIBER ID (SSN OR ID#) PATIENT LAST NAME PATIENT FILL PATIENT LAST NAME PATIENT FILL STATE ZIP CODE DATE OF BIRTH GENDER // MALE // // // MALE // MALE // // // MALE // // // // // // // // // /			

EXAMINER NAME		MD TAX ID#	PATIENT NAME	DATE OF EXAM			
		OD					
STREET ADDRESS			CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH				
			CONVENTIONAL EYEGLASSES? 📮 YES 📮 NO				
CITY	STATE	ZIP CODE	DOES PATIENT HAVE EYEGLASSES PRIOR TO YOUR EX	(AMINATION? YES NO			
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED		DOES PATIENT REQUIRE A PRESCRIPTION CHANGE?	SERVICE CHARGE				
HEREON.			LI YES LI NO IF YES, CHANGES:				
SIGNATURE		DATE	AXISSPHERE/CYLINDER	\$			
I HAVE PRESCRIBED:	SINGLE VISION	BIFOCAL TRIFOCAL	DAPHAKIC CONTACTS: HARD SOFT COS				

TO BE COMPLETED BY DISPENSER (<i>Print</i>)								
DISPENSER NAME TAX ID#	PATIENT NAME				DATE OF SERVICE			
STREET ADDRESS		SPHERE	CYLINDER	AXIS	PRISM	ADD		
	RIGHT							
CITY STATE ZIP CODE	LEFT							
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.		RIALS SUPPLIED		CHARGES	NV	A USE		
	BIFOC/	AL						
SIGNATUREDATE U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE								
E N	🔲 АРНАК	KIC						
S E TRADE NAME WIDTH PAIR ONE								
s GLASS DPLASTIC	HARD	SOFT						
F MANUFACTURER NAME SIZE MODEL OR STYLE		COLOR						
		۲ <u></u>						
	FRAME							
s and a combination and a combination and a combination and a combination and a combined and a c	TOTAL CHA	ARGE						