

AssureCare

13700 Watertower Circle, Suite D Plymouth, Minnesota 55441 (612) 383-4800

**VISION CARE
CLAIM STATEMENT**

PART A - TO BE COMPLETED BY EMPLOYEE

1) EMPLOYEE'S NAME (Last, First, Middle)		2) EMPLOYEE'S SOCIAL SECURITY NUMBER	
3) PATIENT'S NAME (Last, First, Middle)		4) PATIENT'S RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Student <input type="checkbox"/> Spouse <input type="checkbox"/> Handicapped <input type="checkbox"/> Other	
7) EMPLOYEE'S ADDRESS (No., Street, City, State & Zip Code)		8) TELEPHONE NUMBER ()	9) IF STUDENT OVER AGE 19: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
10) EMPLOYER'S NAME AND ADDRESS			
11) IS PATIENT COVERED FOR VISION CARE BY ANOTHER PLAN? No <input type="checkbox"/> Yes <input type="checkbox"/>		VISION PLAN NAME	GROUP NUMBER
			NAME AND ADDRESS OF CARRIER
12) IF CLAIM IS DUE TO ACCIDENT, INDICATE DATE, TIME, PLACE AND HOW ACCIDENT OCCURRED			13) DID ACCIDENT OCCUR AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
14) I hereby authorize any Insurance Company, Organization, Employer, Ophthalmologist, Optometrist, and Optician to release any information with respect to this claim, I certify that the information furnished by me in support of this claim is true and correct.			
SIGNATURE OF EMPLOYEE _____		(DATE SIGNED) _____	
ALSO, SIGNATURE OF DEPENDENT (If Patient, and Not a Minor) _____		(DATE SIGNED) _____	
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR AND/OR DISPENSER <input type="checkbox"/> Yes <input type="checkbox"/> No OF THE VISION CARE BENEFITS OTHERWISE PAYABLE TO ME.			
SIGNED (EMPLOYEE) _____		(DATE) _____	

PART B - TO BE COMPLETED BY DOCTOR

1) DOCTOR'S NAME (Last, First, Middle)		2) ENTER TAXPAPER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER:	
3) DOCTOR'S ADDRESS (No., Street, City, State & Zip Code)			
4) PHONE NUMBER ()	5) TITLE <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> O.D.	6) EXAMINATION DATE	7) HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No
8) EXAM INCLUDE REFRACTION? <input type="checkbox"/> Yes <input type="checkbox"/> No	9) DOES PATIENT REQUIRE A PRESCRIPTION CHANGE NOW? <input type="checkbox"/> One Eye <input type="checkbox"/> Both Eyes <input type="checkbox"/> No		
10) INDICATE DIAGNOSIS OR NATURE OF DISEASE OR INJURY OR VISION DISORDER.			
11) VISUAL ACUITY CORRECTED TO:			
12) I hereby certify that I have performed the services as indicated hereon.			
DOCTOR'S SIGNATURE _____		DATE _____	

PART C - TO BE COMPLETED BY DISPENSER

1) DISPENSER'S NAME (Last, First, Middle)		2) ENTER TAXPAPER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER:	
3) DISPENSER'S ADDRESS (No., Street, City, State & Zip Code)		4) PHONE NUMBER ()	
5) DISPENSER'S TITLE <input type="checkbox"/> Optician <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist	6) FRAME: <input type="checkbox"/> INITIAL <input type="checkbox"/> REPLACEMENT (AGE OF PREVIOUS FRAME: _____)	7) DATE OF SERVICE	
8) TYPE OF LENSES DISPENSED <input type="checkbox"/> None <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular <input type="checkbox"/> Contacts <input type="checkbox"/> Sunglasses <input type="checkbox"/> Other _____			
9) I hereby certify that I have performed the services as indicated hereon.			
DISPENSER'S SIGNATURE _____		DATE _____	

PROFESSIONAL SERVICES	AMOUNT
EXAMINATION CHARGE	
SALES TAX (If Any)	
TOTAL	
AMOUNT PAID BY EMPLOYEE	