

Part B – Examining Physician or Optometrist’s Information

Indicate diagnosis, nature of disease, injury or vision disorder

If contact lenses, would the visual acuity be corrected to 20/70 in the better eye by use of conventional lenses?

yes no

Report of services or attach itemized bill. (If previous form submitted to this carrier, you need to show only dates and services since last report.)

Date of service	Services rendered	Charges
		\$
		\$
Physician’s or optometrist’s name		Phone number
		Total charges
		\$
Physician’s or optometrist’s address (street, city, state, ZIP code)		Federal I.D. number or Tax I.D. number
		Amount paid
		\$
Physician’s or optometrist’s signature		Date
		Your patient’s account number
		Balance due
		\$

Authorization to pay - Sign only if you want benefits paid directly to physician or optometrist.

I authorize payment of vision care benefits to the physician or optometrist described in Part B.

Date

Employee or authorized person’s signature

Part C – Supplier Information (To Be Completed by Dispenser of Prescription other than Prescribing Physician)

Type	Date of purchase	Date of delivery to patient	Charges	Supplier name and address (street, city, state, ZIP code)
Lenses				Supplier phone number
Frames				
Contacts				
Tint				
Coating				
Oversizing				
Other				
Type of lenses: <input type="checkbox"/> single vision <input type="checkbox"/> bifocal <input type="checkbox"/> trifocal <input type="checkbox"/> lenticular <input type="checkbox"/> contact lenses <input type="checkbox"/> disposable contact lenses number of months supplied: _____				Federal I.D. number or Tax I.D. number
			Total charges	Signature of supplier
			\$	Date
				Patient’s account number
				Amount paid
				Balance due
				\$
				\$

Authorization to pay - Sign only if you want benefits paid directly to supplier.

I authorize payment of vision care benefits to the supplier for services described in Part C.

Date

Employee or authorized person’s signature

Payment receipt or cash register receipt for prescription attached (See item 5 below.)

Instructions to Employee

- Complete questions 1 through 18 (Part A) on Page 1 and sign and date line 18.
- Have patient’s physician or optometrist complete the **Examining Physician or Optometrist’s Information** section (Part B) on Page 2.
- Have patient’s supplier (if other than examining physician or optometrist) complete the **Supplier Information** section (Part C) on Page 2.
- Attach itemized bills for expenses not shown on Page 2. If you want benefits paid directly to the physician or optometrist, sign the **Authorization to pay** in section (Part B) on Page 2. If you want benefits paid directly to the supplier (if other than examining physician or optometrist), sign the **Authorization to pay** in section (Part C) on Page 2.
- Attach payment receipt or cash register receipt to claim form if prescription is being filled by someone other than the examining physician or optometrist.