



SELF-FUNDED PLANS, INC.
 1432 Hamilton Avenue
 Cleveland, Ohio 44114-1146
 (216) 566-1455 or
 1-800-722-7374

VISION CARE BENEFIT CLAIM FORM

HOW TO FILE A CLAIM

1. Complete the Employee's Statement below. A separate Employee Statement is required for each patient. To ensure prompt processing, answer every question.
2. Have your physician complete the Statement of Physician or Optometrist.
3. Have the provider of materials complete the Statement of Provider.
4. Mail completed form to:
SELF-FUNDED PLANS, INC.
 1432 HAMILTON AVENUE
 CLEVELAND, OHIO 44114-1146

EMPLOYEE'S STATEMENT

NAME OF EMPLOYER		ACCOUNT NO.	
EMPLOYEE'S NAME (Please print full name)	EMPLOYEE'S SOCIAL SEC. #	MARITAL STATUS	
HOME ADDRESS		<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated	
Street	City	State	Zip Code
PATIENT'S NAME	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	PATIENT'S BIRTHDATE	

IS SPOUSE EMPLOYED? Yes No
 If "Yes" give name, address and telephone no. of employer.
 If "No" give name, location of last employer and date last worked.

If patient is a child 19 or over and in school, give full name and address of school.

IS PATIENT COVERED BY ANOTHER VISION PLAN?

- Any other Benefit Plan, Group Insurance, Union Welfare Plan or other arrangement of coverage for individuals in a group? Yes No
- Blue Cross, Blue Shield or any other prepayment arranged on a group basis? Yes No
- Any other coverage provided by an employer or any federal, state, or other government agency? Yes No
- No-fault automobile insurance as a result of injuries sustained in an automobile accident? Yes No
- If "yes" furnish name and address of employer, union, insurance company or governmental agency, type of coverage, and policy number below.

WAS ILLNESS OR INJURY DUE IN ANY WAY TO PATIENT'S OCCUPATION, AUTO ACCIDENT OR ANY OTHER TYPE OF ACCIDENT?
 If yes, circle appropriate answer and give details.

I hereby certify that the above statements are true, accurate and complete. I authorize any person or institution rendering care, or any person or organization (including my employer) in possession of information concerning insurance or other benefits covering me or my dependents, to furnish to, or receive from SELF-FUNDED PLANS, INC. or its authorized representative, full information regarding such care or other benefit information. A photocopy of this authorization shall be as valid as the original.

NAME OF PATIENT (Print) _____ SIGNATURE OF EMPLOYEE _____ DATE _____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:
 I hereby authorize payment of benefits directly to the Provider signing the Statement of Physician or Optometrist or Statement of Provider. _____
 Signed (Employee or Authorized Person)

STATEMENT OF PHYSICIAN OR OPTOMETRIST

NAME OF PATIENT _____

1. Indicate nature of disease, injury or vision disorder. _____

2. Date of examination _____

3. If Contact Lenses prescribed, indicate reason: Cataract Sugery Irregular Astigmatism
 Keratoconus Irregular Corneal Curvature Other

4. If Contact Lenses were dispensed for Keratoconus, Irregular Astigmatism or Irregular Corneal Curvature, was it confirmed by Keratometric readings? Yes No

5. Could visual acuity be corrected to 20/70 in the better eye by use of conventional lenses? Yes No

6. TO OPHTHAMOLOGIST ONLY: Was the patient referred to you for an examination of an unresolved visual problem by an optometrist who performed a vision examination within the last 60 days? Yes No

7. Comments _____

8. Physician's or Optometrist's Name, Address, Zip Code, Phone Number

Name (As it appears on IRS form W-9) _____

Physician
 Optometrist

Number _____

Street _____

City _____

State _____

Zip Code _____

Phone _____

9. Taxpayer ID No. _____
 (As it appears on IRS form W-9)

10. Total Exam Charge \$ _____

11. SIGNATURE OF PHYSICIAN OR OPTOMETRIST _____

DATE SIGNED _____

STATEMENT OF PROVIDER

12. Check materials furnished and indicate separate charges (including taxes) where shown:

13. DATE OF SERVICE: _____

	SPHERE	CYLINDER	AXIS	PRISM	ADD
O.D.					
O.S.					

- Plastic Basic Lenses \$ _____
- Glass Additives
- Single Vision Tint #() \$ _____
- Bifocal Gradient \$ _____
- Trifocal Photochromic \$ _____
- Lenticular Oversized \$ _____
- Contact Other _____
- 1/2 Pair _____ \$ _____

15. Lens Mfr. _____ Seg. Style/Width _____ Trade Name _____

16. Comments _____

17. Frame Mfr. _____ and Frame Name _____

18. Indicate Parts: Complete Partial Composition ZYL Metal ZYL Comb.

19. Dispenser's Name, Address, Zip Code & Phone No.
 (Complete Only if different from above)

Name (As it appears on IRS form W-9) _____

Physician
 Optometrist
 Optician

Number _____

Street _____

City _____

State _____

Zip _____

Phone _____

20. Taxpayer ID No. (As it appears on IRS form W-9) _____

21. Total Lens Charge \$ _____

22. Frame Charge \$ _____

23. Tax \$ _____

24. Total Charge \$ _____

25. SIGNATURE OF DISPENSER _____

DATE SIGNED _____

EXAMINATION

FRAMES-LENSES