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

Capital Blue Cross Vision

Capital

CLAIM FOR VISION CARE EXPENSE
FOR NON-PARTICIPATING PROVIDERS

NATIONAL VISION ADMINISTRATORS
PO BOX 2187 / CLIFTON, NEW JERSEY 07015
800.905.4102

TO BE COMPLETED BY EMPLOYEE (*Print*)

SUBSCRIBER INFORMATION			PATIENT INFORMATION			
LAST NAME	FIRST NAME		SUBSCRIBER ID (SSN OR ID#)			
STREET ADDRESS			PATIENT LAST NAME	PATIENT FIRST NAME		
CITY	STATE	ZIP CODE	DATE OF BIRTH	GENDER	STATUS	
			/ /	☐ MALE ☐ FEMALE	☐ 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)? ☐ YES ☐ NO
2) SAFETY GLASSES? ☐ YES ☐ NO 3) CATARACT SURGERY? ☐ YES ☐ 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? ☐ YES ☐ NO IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE SPACE PROVIDED.

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST (*Print*)

EXAMINER NAME ☐ MD ☐ OD	TAX ID#	PATIENT NAME	DATE OF EXAM
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 EXAMINATION? ☐ YES ☐ NO	
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON. SIGNATURE_____ DATE_____		DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? ☐ YES ☐ NO IF YES, CHANGES: AXIS_____ SPHERE/CYLINDER_____	SERVICE CHARGE $

I HAVE PRESCRIBED: ☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ APHAKIC CONTACTS: ☐ HARD ☐ SOFT ☐ COSMETIC ☐ MEDICALLY REQUIRED

TO BE COMPLETED BY DISPENSER (*Print*)

DISPENSER NAME	TAX ID#	PATIENT NAME	DATE OF SERVICE
STREET ADDRESS			
CITY	STATE ZIP CODE		

Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD
RIGHT					
LEFT					

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.

SIGNATURE_____ DATE_____

LENSES

U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE

TRADE NAME WIDTH ☐ PAIR ☐ ONE ☐ GLASS ☐ PLASTIC

FRAMES

MANUFACTURER NAME SIZE MODEL OR STYLE

FRAME NUMBER ☐ PLASTIC ☐ METAL ☐ COMBINATION ☐ NEW ☐ PATIENT'S

MATERIALS SUPPLIED	CHARGES	NVA USE
☐ SINGLE VISION		
☐ BIFOCAL		
☐ TRIFOCAL		
☐ APHAKIC		
☐ CONTACTS ☐ HARD ☐ SOFT		
☐ TINT #_____ COLOR_____		
☐ OTHER _____		
FRAME		
TOTAL CHARGE		