

VISION CARE CLAIM FORM

IDENTIFICATION OF THE INSURED	
Last Name	First Name
Address	Apt.
City	Province
Telephone	Postal Code
Date of Birth (YYYY/MM/DD)	Employee Cert./SIN/ID No.
Policy/Group/Plan No.	Account No./Division/Section
Insurance Company: ClaimSecure	Employer Name:

IDENTIFICATION OF THE PATIENT	
Last Name	First Name
If Patient address is different - please complete:	
Patient Identification Number	Date of Birth (YYYY/MM/DD)
Relationship with the insured <input type="checkbox"/> PLAN MEMBER <input type="checkbox"/> DEPENDANT <input type="checkbox"/> SPOUSE <input type="checkbox"/> SPECIAL DEPENDANT <input type="checkbox"/> STUDENT	
NAME OF EDUCATIONAL INSTITUTION IF APPLICABLE:	

IDENTIFICATION OF THE PROVIDER	
Name	
Address	
City	Province
Telephone	Postal Code
Permit No./License No.	Insurance Carrier Provider No.

SPOUSE/ALTERNATE COVERAGE - COORDINATION OF BENEFITS	
WCB/WSIB?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have other Vision Care coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please complete the following:	
Name of Insurer/Plan _____	Name of Insured _____
Effective Date of Coverage (YYYY/MM/DD) _____	
Policy/Group/Plan No. _____	Coverage <input type="checkbox"/> Family <input type="checkbox"/> Single
Alternate coverage/Employee Cert./SIN/ID No. _____	
Spouse or Alternate Date of Birth (YYYY/MM/DD) _____	
If this is your first claim, or if information has changed, please specify:	
Either a copy of the payment or denial letter from the primary carrier must be attached.	

DETAILS OF THE PRESCRIPTION						
		Sphere	Cylinder	Axis	Prism	Add
New Rx	Right					
	Left					
Old Rx	Right					
	Left					
Plastic	<input type="checkbox"/>	Type of right lens _____				
Hardened	<input type="checkbox"/>	chem Type of left lens _____				
	<input type="checkbox"/>	Heat Tint _____				
Oversize:		_____ mm				

<input type="checkbox"/> initial prescription	<input type="checkbox"/> prescription sunglasses	<input type="checkbox"/> Rx duplicate
<input type="checkbox"/> new prescription	<input type="checkbox"/> contact lenses	<input type="checkbox"/> replacement (loss or breakage)
<input type="checkbox"/> safety glasses	<input type="checkbox"/> lenses only	
<input type="checkbox"/> post cataract		
<input type="checkbox"/> other: (indicate any medical conditions or disease) _____		
If claim is for contact lenses:		
Can visual acuity be restored to	<input type="checkbox"/> 20/70?	<input type="checkbox"/> 20/40?
Are the contact lenses medically necessary due to keratoconus, irregular astigmatism, aphakias, or irregular corneal curvature?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can visual acuity be improved by at least two lines on the Snellan chart over the best possible vision with glasses?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CLAIM DETAILS						
Please attach copies of the original Paid in Full receipt if claim payable to Insurer						
DISPENSING DATE YYYY/MM/DD	SERVICE CODE	SERVICE DESCRIPTION (When required, specify dispensing fees separately.)	Quantity	Fee	Dispensing	Price
				Total	\$	
				Patient Paid	\$	

ASSIGNMENT DETAILS: I hereby assign my benefits payable from this claim and authorize payment directly to the above Service Provider <i>Insured's signature</i> _____
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PICK UP DATE (YYYY/MM/DD) _____	Balance to be paid to provider \$ _____
I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member.	
I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.	
A copy of this authorization shall be as valid as the original.	
<i>Insured's signature:</i> _____	<i>Date:</i> _____
<i>Provider's signature:</i> _____	<i>Date:</i> _____

CONTRACT HOLDER/ADMINISTRATOR DETAILS: Dates Eligible _____ (YYYY/MM/DD) Dependent Eligible _____ Terminated _____
Is treatment the result of an occupational illness or injury, or otherwise related to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contract Holder and Location: _____ <i>Signature of Authorized Official:</i> _____ <i>Date:</i> _____ <i>Administrator Signature:</i> _____ (YYYY/MM/DD)