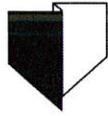


# Vision Claim Form



**MERITAIN<sup>SM</sup>**  
**HEALTH**  
An Aetna Company

Complete and send to:  
Meritain Health  
P.O. Box 853921  
Richardson, TX 75085-3921  
Fax: 1.763.852.5057

For ALL claims, this area must be filled in completely.

<b>Employee Information</b>		
Employee's Name (last, first, middle initial)		Employee ID Number Group #10974 --
Address		Employee's Date of Birth
City	State	Zip Code
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		

If the patient is a dependent, please complete ALL of the following. If the patient is the employee, go directly to the area below the shaded box.

<b>Patient Information</b>	
Patient's Name (if other than employee)	Patient's ID Number Group #10974 --
Patient's Date of Birth (Month, Day, Year)	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child
If child, is (s)he married? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is patient covered by another Employer Group Plan or Retirement Group Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete the two items below)	
Name of Employer	Group Number
Name and address of Insurance Company or Organization	
<b>Release</b>	
Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud, submits an application for coverages, or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Criminal and/or Civil penalties can result from such acts.	
I hereby authorize payment of these benefits be send directly to:	
<input type="checkbox"/> Provider of Service <input checked="" type="checkbox"/> <b>Employee (attach itemized bill or receipt)</b>	
Patient's Signature (parent or guardian if claim is on a minor)	Date

The below sections are to be completed by the Provider.

<b>Exam</b>		
Indicate the nature of disease, injury or vision disorder	Date of examination	Name of provider performing services
Refraction? Yes <input type="checkbox"/> No <input type="checkbox"/> Contact Lenses? Yes <input type="checkbox"/> No <input type="checkbox"/>	Address	
Tonometry? Yes <input type="checkbox"/> No <input type="checkbox"/> Cataract Surgery? Yes <input type="checkbox"/> No <input type="checkbox"/>	City	
<b>Examination Charge: \$</b>	State	Zip Code
<b>Amount paid by employee: \$</b>	Provider's Social Security or Tax ID Number (required by law):	
Signature of provider	Degree/Title	Date

<b>Lenses</b>				<b>Frames</b>			
Date ordered:	Date dispensed:	<input type="checkbox"/> Pair <input type="checkbox"/> 1/2 Pair		Date ordered	Date dispensed	Parts <input type="checkbox"/> Complete <input type="checkbox"/> Partial	
Sphere	Cylinder	Axis	Prism	Add	<b>Frame Charge \$</b>		
OD					Name of provider performing services (please print)		
OS					Address		
<b>Type Lens:</b>				City, State, Zip			
<input type="checkbox"/> Single vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular				Provider's Social Security Number or Tax ID Number			
<input type="checkbox"/> Contact Lenses				Signature of provider			
<input type="checkbox"/> Oversized Lenses				Degree/Title			
<input type="checkbox"/> Sunglasses				Date			
<input type="checkbox"/> Tint #				Total Charge: \$			
<input type="checkbox"/> Photosensitive – i.e. Brown, Gray, etc.				Amount paid by employee: \$			
<input type="checkbox"/> Other							
Lens Manufacturer:							
<b>Lens Charge \$</b>							

IMPORTANT: CLAIMS CANNOT BE PAID UNTIL THE CLAIM FORM IS PROPERLY COMPLETED AND RECEIVED. Do not send this form through your employer. ATTACH PROVIDER BILLING. If you require assistance in presenting this claim, call your Service Delivery Team at the number listed on your member ID Card.