DELTA HEALTH SYSTEMS

REFER TO YOUR I.D. CARD FOR PROPER MAILING ADDRESS

EMPLOYEE ID NUMBER

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VISION CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION

1. PATIENT'S NAME	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE ☐ FEMALE ☐ 7. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	6. EMPLOYEE'S ADDRESS (STREET, CITY, STATE, ZIP CODE) ☐ CHECK HERE IF NEW ADDRESS

8. OTHER HEALTH INSURANCE COVERAGE
IS PATIENT COVERED BY ANY OTHER PLAN? ☐ YES ☐ NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER:

IDENTIFICATION NUMBER _____ NAME OF EMPLOYER _____

TYPES OF COVERAGE BY CARRIER: ☐ MEDICAL ☐ DRUG ☐ DENTAL ☐ VISION

EFFECTIVE DATE OF COVERAGE _____ TERMINATION DATE OF COVERAGE _____

9. IS THIS CONDITION CAUSED BY EMPLOYMENT? ☐ YES ☐ NO	10. DOES CLAIM INVOLVE AN INJURY? YES ☐ NO ☐ WAS INJURED PERSON AT WORK? YES ☐ NO ☐ DATE AND TIME OF INJURY _____
11. I AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____	12. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW. SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____

TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST ONLY

1. IS THIS A CHANGE IN PRESCRIPTION? ..... YES ☐ NO ☐
2. ARE THE LENSES OR FRAMES FOR EITHER SUNGLASSES OR OTHER NON-CORRECTIVE PURPOSES? ..... YES ☐ NO ☐
3. ARE NEW LENSES OR FRAMES FOR: DUPLICATION OF EXISTING ITEMS? ..... YES ☐ NO ☐
   REPLACEMENT OF LOST OR BROKEN LENSES? ..... YES ☐ NO ☐
   REPLACEMENT OF BROKEN FRAMES? ..... YES ☐ NO ☐
4. WERE THESE VISION CARE SERVICES REQUIRED AS A CONDITION OF THE PATIENT'S EMPLOYMENT? ..... YES ☐ NO ☐
5. TYPE OF LENSES PRESCRIBED: ☐ SINGLE VISION ☐ TRIFOCAL ☐ LENTICULAR ☐ BIFOCAL ☐ PROGRESSIVE ☐ CONTACTS

DATE(S) OF SERVICE	SERVICE / PROCEDURE	DIAGNOSIS	CHARGE

DATE | SIGNATURE (ATTENDING DOCTOR) | DEGREE | FED.TAX NO. | TELEPHONE

STREET ADDRESS | CITY OR TOWN | STATE | ZIP CODE

FORM NO. 107 REV. 4/07