

**PLEASE SUBMIT ORIGINAL ITEMIZED BILLS WITH A COMPLETED AND SIGNED CLAIM FORM!**  
**IMPORTANT:** These forms are electronically scanned, please do not use HIGHLIGHTER or anything else that might distort the information on this form.

TYPE  
OR  
PRINT



Post Office Box 875, Oakland, NJ 07436  
 800 / 225-1345 or 201/ 337-0555  
 See reverse side for claim filing information



**PATIENT INFORMATION (TO BE COMPLETED BY INSURED)**

1. INSURED'S Employer		2. INSURED'S Soc. Sec. No.	3. INSURED'S Name, Address and Phone No. <input type="checkbox"/> If this is a new address, you must notify your employer	
4. PATIENT'S Name (First name, middle initial, last name)		5. PATIENT'S Date of Birth		
6. PATIENT'S Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. PATIENT'S relation to INSURED <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other	8. PATIENT'S Status: a <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other b. Employed full-time Yes <input type="checkbox"/> No <input type="checkbox"/> c. Student full-time Yes <input type="checkbox"/> No <input type="checkbox"/>		
9. Is PATIENT'S condition related to: a. <input type="checkbox"/> Employment? (Current or Previous) b. <input type="checkbox"/> Auto Accident? Place _____ (State) c. <input type="checkbox"/> Other Accident? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. If injured: → Describe how and where ► → Date _____ → Will you sue? YES <input type="checkbox"/> NO <input type="checkbox"/>		10. PATIENT'S Address (If different from INSURED'S) and Phone No. <input type="checkbox"/> If this is a new address, you must notify your employer
11. INSURED'S Date of Birth	12. INSURED'S Sex <input type="checkbox"/> M <input type="checkbox"/> F	13. Is INSURED Now actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO or under <input type="checkbox"/> COBRA	14. Date INSURED'S hired	

**15. OTHER HEALTH INSURANCE COVERAGE - SECTIONS BELOW MUST BE ANSWERED FOR CLAIM TO BE APPROVED. ◀**

A. INSURED'S SPOUSE'S employer (If unmarried or spouse is unemployed check none)

None Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

B. Name and address of other insurance company or H.M.O. If none, check None

None

C. Name of person covered - last & first \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex  M  F Policy No. Identification \_\_\_\_\_

D. Person covered & named in item "C" above is insured's:  Self  wife  Husband  Daughter  Son  Other (Describe)

16. I authorize the release of any medical information necessary to process this request

Signed (PATIENT or Authorized person) \_\_\_\_\_ Date \_\_\_\_\_

17. I authorize payment of benefits directly to the Physician or Supplier named below.

Signed (INSURED or Authorized person) \_\_\_\_\_

**EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST INFORMATION**

PHYSICIAN NAME, DEGREE, ADDRESS AND PHONE NUMBER	YES	NO	IF YES, EXPLAIN	
	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
	IS TREATMENT RESULT OF AUTO ACCIDENT?			
	OTHER ACCIDENT?			
ARE ANY SERVICES COVERED BY ANOTHER PLAN?				

DIAGNOSIS OR NATURE OF DISEASE, INJURY OR VISION DISORDER

DID PATIENT HAVE GLASSES PRIOR TO THIS EXAMINATION? NO <input type="checkbox"/> YES <input type="checkbox"/> ► WHAT TYPE? <input type="checkbox"/> CONVENTIONAL <input type="checkbox"/> CONTACTS	DOES PATIENT REQUIRE A LENS PRESCRIPTION CHANGE AT THIS TIME? NO <input type="checkbox"/> YES <input type="checkbox"/> ► WHY?	NEW FRAMES REQUIRED NO <input type="checkbox"/> YES <input type="checkbox"/>
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MATERIAL AND NUMBER OF EACH PRESCRIBED

FRAMES  SINGLE VISION  BIFOCAL  TRIFOCAL  CONTACT LENSES  OTHER (Describe)

IF TINTED LENSES, SUNGLASSES AND/OR SAFETY GLASSES PRESCRIBED, EXPLAIN

DATE OF SERVICES	SERVICES RENDERED	CHARGES

PHYSICIAN SIGNATURE	SSN OR EIN NUMBER	TOTAL FEE	
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**DISPENSER OF PRESCRIPTION INFORMATION (or attach itemized statement)**

DISPENSER NAME, TITLE, ADDRESS AND PHONE NUMBER	FEE FRAMES \$ _____ LENSES \$ _____ CONTACTS \$ _____ DATE ORDERED _____ DISPENSER SSN OR EIN _____ DISPENSER SIGNATURE _____
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ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION WITH THE INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR PERSON IS GUILTY OF A FELONY.

1. COMPLETE THE “**PATIENT INFORMATION**” SECTION (ITEMS 1 THROUGH 14) ON THE REVERSE SIDE OF THIS FORM

If you wish your vision benefits paid directly to your doctor, sign ITEM 17.  
A separate form must be submitted for each family member.

2. HAVE YOUR DOCTOR COMPLETE THE “**EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST INFORMATION**” SECTION OR SUBMIT COMPLETELY ITEMIZED BILLS.

An itemized bill is one that shows the PATIENT’S name, relationship to INSURED, date of service, type of service rendered, and the nature of the condition being treated

3. HAVE THE PERSON FILLING YOUR EYE CARE PRESCRIPTION COMPLETE THE “**DISPENSER OF PRESCRIPTION INFORMATION**” SECTION OR SUBMIT ITEMIZED STATEMENT.

4. THE COMPLETED FORM AND ITEMIZED BILLS MUST BE SENT TO THE ADDRESS BELOW:

**INSURANCE DESIGN ADMINISTRATORS**

**P.O. BOX 875**

**OAKLAND, NJ 07436**

**1-800-225-1345 or 201-337-0555**

**IMPORTANT REMINDER**

Please be sure you have provided the INSURED’S Social Security Number.

**NOTE TO CLAIMANT**

Please attach all itemized bills and supporting documents to this completed and signed claim form. Do not use highlighter or anything else that might distort the information on this form; **otherwise, your claim will be delayed.**

**NOTE TO ATTENDING PHYSICIAN**

If the PATIENT named will be under continuous treatment for the stated condition, there will be no need to fill out an ATTENDING PHYSICIAN’S statement each time a bill is submitted. An itemized bill will be acceptable for processing. However, if the patient consults you for any other condition, a new ATTENDING PHYSICIAN’S statement will be necessary.

INCOMPLETE CLAIM FORMS WILL BE RETURNED FOR COMPLETION. ALSO, IF YOU OR YOUR IMMEDIATE FAMILY ARE COVERED BY ANY OTHER INSURANCE PROGRAMS, INCLUDING MEDICARE, THE “**OTHER VISION CARE INSURANCE COVERAGE**” SECTION MUST BE COMPLETED EACH TIME YOU SUBMIT A CLAIM FORM OR YOUR FORM WILL BE RETURNED.