vision Group Claim Form

Ameritas Life Insurance Corp. of New York

Ameritas

Group Claims Adjusters / P.O. Box 82595 Lincoln, NE 68501-2595 / Toll Free 800-659-5556 / Fax 402-467-7336 / Web ameritas.com

Part 1: To be completed by Employee

1. Patient's full name (first, middle initial, last)	2. Patient birthdate (MM/DD/YY) / /	3. Relationship to employee ☐ Self ☐ Spouse ☐ Child ☐ Other	4. Sex ☐ M ☐ F
5. Employee's full name (first, middle initial, last)	6. Employee's identification number	Employee's birthdate (MM/DD/YY) / /	

7. Employee's mailing address (street address or P.O. Box, City, State, ZIP)	8. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER Is patient a full-time student? ☐ Yes ☐ No If Yes, name and address of school:
Email address:	

9. Employer (company) name and address	10. Group number	Division number	Certificate number
	026-301542	2	

Questions 11 and 12 must be completed with each claim submission.

11. Is patient covered by another vision plan? ☐ Yes ☐ No	Name and address of other carrier	Policy number	Name and address of other employer:

12. Other employee/subscriber name	Employee/subscriber identification number	Date of birth (MM/DD/YY) / /	Relationship to patient

13. **I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of treatment. I certify these statements to be true and complete to the best of my knowledge.**	Check one box only: 14A. ☐ **Please send payment to me OR** 14B. ☐ **Please pay provider below**
X _____ Signature (patient, or parent if minor) _____ Date	X _____ Signature (insured person) _____ Date

Part 2: To be completed by Attending Vision Provider.

IMPORTANT: Please attach an itemized receipt including provider's name and address, specific procedures and materials purchased. If this is attached, you will not need to complete Part 2.

15. Vision care provider name and address	**For Yes answers to questions 17-19, enter a brief description and dates.** 17. Is treatment result of occupational illness or injury? ☐ Yes ☐ No
	18. Is treatment result of auto accident? ☐ Yes ☐ No
Specialty / Phone number	19. Other accident? ☐ Yes ☐ No
Email / Fax number	20. This is a (please check one): ☐ Statement of actual services ☐ Pretreatment estimate
16. Federal Tax ID Number ☐ SSN ☐ TIN / NPI (National Provider Identifier)	21. Is this for LASIK/PRK? ☐ Yes ☐ No
License #	22. Date of Service / Exam / Materials

23. **Examination and Treatment Record** Please include date of service, description of services, procedure code and fee.

Service	CPT Code	Fee	Lenses	CPT Code	Fee	Options	CPT Code	Fee
LASIK/ PRK left eye		$	Single		$	Anti-reflective		$
right eye		$	Bifocal		$	Scratch resist		$
Exam		$	Trifocal		$	Tint		$
Lens fitting		$	Progressive		$	Hi-index		$
Refraction		$	Lenticular		$	Edge polish		$
Other		$	Contacts		$	Other		$
Frames		$	Other		$	Discounts		

24. Remarks	25. Total $

26. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees subm itted are the fees I have charged and intend to collect for those purposes.	27. Address where treatment was performed
X _____ Signature (Provider) _____ Date	