Advantek Benefit Administrators
Vision Claim Form

P.O. Box 45007
Fresno, CA 93718
866-556-7655

PART 1 – TO BE COMPLETED BY EMPLOYEE

1. EMPLOYEE NAME: *(first name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. PATIENT'S NAME: *(first name, middle initial, last name)*
4. EMPLOYEE SOCIAL SECURITY NUMBER	5. PATIENT'S SEX ❑ MALE ❑ FEMALE	6. IS SPOUSE EMPLOYED? ❑ YES ❑ NO EMPLOYER'S NAME:
7. EMPLOYER OR GROUP NO.	8. PATIENT'S RELATIONSHIP TO INSURED ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER	TELEPHONE NUMBER:
9. EMPLOYEE'S ADDRESS *(street, city, state, zip code)*	10. WAS THE SERVICE REQUIRED AS A RESULT OF AN ACCIDENT? ❑ YES ❑ NO	11. OTHER VISION INSURANCE COVERAGE ❑ YES ❑ NO *(Enter name of Policyholder, Plan Name, Address and Policy Number)*

12. PATIENT'S OR AUTHORIZED PERSON'S SGNATURE I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. SIGNED _____ DATE _____ **IF PART 1 IS COMPLETE AND SUBMITTED WITH A DETAILED AND LEGIBLE STATEMENT FROM THE PROVIDER, IT IS NOT NECESSARY COMPLETE PART 2 OR PART 3 OF THIS FORM.**	13. I AUTHORIZE PAYMENT OF VISION BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPLIER FOR SERVICE DESCRIBED BELOW. SIGNED (*Employee or Authorized Person*) _____

PART 2 – TO BE COMPLETED BY THE DOCTOR

1. Has patient worn glasses before this examination? ❑ YES ❑ NO

2. If Yes, state the reason for replacement _____

3. Does your examination indicate that glasses should be prescribed? ❑ YES ❑ NO

4. If you prescribed glasses, check type: ❑ Single Vision ❑ Bifocal ❑ Trifocal ❑ Lenticular

Other (Describe) _____

5. Has cataract surgery been performed? ❑ YES ❑ NO Date _____

6. Can visual acuity be restored to at least 20/70 in the better eye with conventional glasses? ❑ YES ❑ NO

7. Diagnosis _____

8. Examination Date _____ Charge _____

9. SIGNATURE OF PROFESSIONAL PROVIDER OR SUPPLIER (*I certify that I am legally qualified to perform the reported services and that the above services are not industrial safety glasses, goggles or nonprescription sunglasses.*) SIGNED _____ DATE _____	10. HAS FEE BEEN PAID? ❑ YES ❑ NO 11. PROVIDER'S TAX ID NO.	12. PROFESSIONAL PROVIDER OR SUPPLIER'S NAME, ADDRESS AND ZIP CODE PHONE NUMBER _____

PART 3 – MATERIALS AND PROFESSIONAL SERVICES

	DATE	CHARGE	
A. Single Vision Lenses			
B. Bifocal Lenses			
C. Trifocal Lenses			
D. Lenticular Lenses			
E. Contact Lenses			
F. Frame			
G. Number of Lenses Provided ❑ ONE ❑ TWO			

H. Provider's Name _____

I. Address _____

J. Provider's Signature

_____

K. Tax ID# _____

L. Phone # _____

Advantek Benefit Administrators
Vision Claim Form
P.O. Box 45007
Fresno, CA 93718
866-556-7655

How to Complete a Vision Claim Form

Part 1 – Employee

If Part 1 is complete and submitted with a detailed and legible statement from the provider, it is not necessary complete Part 2 or Part 3 of this form.

Answer all questions in blocks numbered 1 through 11. Sign and date block number 12. Your claim cannot be processed without your signature in this block.

If you want the benefit issued to the physician or provider of service, sign block number 13. If you have paid the provider of service, do not sign block number 13. Have physician complete Part 2.

Part 2 – Physician

Answer all questions in blocks numbered 1 through 12. If you are providing the complete service and materials continue through Part 3, answering all questions in A through L and mail to the address at the top of this form.

Part 3 – Materials and Professional Services

Answer all questions A through L and mail to the address at the top of this form.

If you have any questions please call the toll-free number on the top of this form.