

CLAIM INSTRUCTIONS

EMPLOYEE:

- Use this form to obtain reimbursement for services.
- Complete the employee section of the form.
- Sign and date the form after checking for completeness.
- Attach copy of itemized receipts.
- Submit the form to:

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187
CLIFTON, NEW JERSEY 07015
TOLL FREE 800-672-7723

If you have any questions, please contact NVA at 800-672-7723.

CLAIM FOR VISION CARE EXPENSE FOR NON-PARTICIPATING PROVIDERS



NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
800-672-7723

TO BE COMPLETED BY EMPLOYEE (*Print*)

LAST NAME		FIRST		CARD MEMBER				+		+			
STREET ADDRESS				FIRST NAME	DATE OF BIRTH		GENDER		STATUS				
					/ /		MALE ☐ FEMALE ☐		SPOUSE ☐ CHILD ☐				
CITY		STATE		ZIP CODE		SPONSOR NAME			MARITAL STATUS				
									☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED				
I HEREBY CERTIFY THAT THE PATIENT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FOR THE BENEFITS AND THAT I HAVE RECEIVED THE SERVICES DESCRIBED. I ALSO CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN ON THE JOB INJURY OR COVERED UNDER ANOTHER VISION PROGRAM. I FURTHER AUTHORIZE THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITER, SPONSOR, POLICY HOLDER AND THE EMPLOYER.													
EMPLOYEE'S SIGNATURE _____										DATE _____			
IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? ☐ YES ☐ NO 2) SAFETY GLASSES? ☐ YES ☐ NO 3) CATARACT SURGERY? ☐ YES ☐ NO IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN THE SPACE PROVIDED.													
IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? ☐ YES ☐ NO IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE SPACE PROVIDED.													

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST (*Print*)

EXAMINER NAME	☐ MD ☐ OD	TAX ID#	PATIENT NAME	DATE OF EXAM
STREET ADDRESS			CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL EYEGLASSES? ☐ YES ☐ NO	
CITY	STATE	ZIP CODE	DOES PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? ☐ YES ☐ NO	
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.			DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? ☐ YES ☐ NO IF YES, CHANGES:	
SIGNATURE _____			AXIS _____	SERVICE CHARGE \$ _____
I HAVE PRESCRIBED: ☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ APHAKIC CONTACTS: ☐ HARD ☐ SOFT ☐ COSMETIC ☐ MEDICALLY REQUIRED				

TO BE COMPLETED BY DISPENSER (*Print*)

DISPENSER NAME		TAX ID#		PATIENT NAME			DATE OF SERVICE	
STREET ADDRESS				Rx	SPHERE	CYLINDER	AXIS	PRISM
CITY				RIGHT				ADD
STATE				LEFT				
ZIP CODE				MATERIALS SUPPLIED		CHARGES		NVA USE
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.				☐ SINGLE VISION				
SIGNATURE _____				☐ BIFOCAL				
DATE _____				☐ TRIFOCAL				
L E N S E S	U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE			☐ APHAKIC				
	TRADE NAME	WIDTH	☐ PAIR ☐ ONE	☐ CONTACTS				
			☐ GLASS ☐ PLASTIC	☐ HARD ☐ SOFT				
				☐ TINT # _____ COLOR _____				
F R A M E S	MANUFACTURER NAME			☐ OTHER _____				
	SIZE	MODEL OR STYLE						
	FRAME NUMBER	☐ PLASTIC ☐ METAL ☐ NEW	FRAME					
		☐ COMBINATION ☐ PATIENT'S	TOTAL CHARGE					