**MUTUAL HEALTH SERVICES**℠

P.O. Box 5700 ♦ Cleveland, Ohio 44101
800-367-3762 ♦ Fax (330) 666-6685

# STATEMENT OF CLAIM FOR VISION CARE

NOTE: COMPLETE THE SECTION BELOW. IF YOU ARE REQUESTING REIMBURSEMENT, OBTAIN FROM THE DOCTOR ITEMIZED BILLS SHOWING THE NAME OF THE PATIENT, DATE OF SERVICE, THE CHARGES AND EXACTLY WHAT THE CHARGES WERE FOR. SUBMIT THIS FORM AND THE BILL TO THE ABOVE ADDRESS. REIMBURSEMENT WILL BE ACCORDING TO YOUR PLAN SCHEDULE OF BENEFITS. IF YOU WANT PAYMENT MADE DIRECTLY TO THE DOCTOR, PLEASE HAVE THE BOTTOM OF THIS FORM COMPLETED BY THE PROVIDER.

|  TO BE COMPLETED BY EMPLOYEE | COMPLETE ONLY IF A DEPENDENT CLAIM |
|---|---|
| 1. _____<br>PRINT FULL NAME | _____<br>FULL NAME OF DEPENDENT |
| 2. _____<br>HOME ADDRESS | _____<br>BIRTH DATE |
| 3. _____<br>CITY          STATE      ZIP CODE | _____<br>RELATIONSHIP TO PATIENT |
| 4. _____<br>GROUP NUMBER | _____<br>EMPLOYEE SOC. SEC. NUMBER |

5. Were any of the expenses covered by Workers' Compensation?   ☐ YES   ☐ NO

6. Is the person for whom claim is being made covered under any other vision care plan?   ☐ Yes ☐ No
   If Yes, name and address of other company: _____

The above answers are true to the best of my knowledge. I hereby authorize any doctor or optician, any insurance company or other organization to release any information required, including benefits paid or payable.

_____          _____
DATE                                              EMPLOYEE'S SIGNATURE

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE FOR DIRECT PAYMENT OF BENEFITS TO THE OPTOMETRIST OR OPTHALMOLOGIST. (*This assignment may be honored if signed by a dependent or person other than the employee.*)

DATED: _____          SIGNED: _____

## TO BE COMPLETED BY EXAMINING DOCTOR (*Optometrist or Opthalmologist*)

1. _____          _____
   NAME OF PATIENT EXAMINED                     DATE OF EXAMINATION

2. CHARGE OF EXAM   $ _____   TONOMETRY   YES _____   NO _____

3. DOCTOR'S NAME   _____          _____
                                      PLEASE PRINT                                     DOCTOR'S SIGNATURE

   ADDRESS   _____

   TELEPHONE   _____

## TO BE COMPLETED BY SUPPLIER OF LENSES AND/OR FRAMES (*Optometrist or Optician*)

1. _____          _____
   NAME OF PERSON FOR WHOM GLASSES WERE FURNISHED          DATE GLASSES PROVIDED

| 2. CHARGE FOR LENSES | Single Vision | L☐ | R☐ | Trifocal | L☐ | R☐ | Lenticular | L☐ | R☐ |
|---|---|---|---|---|---|---|---|---|---|
|  | Bifocal | L☐ | R☐ | Contacts | L☐ | R☐ | | | |

| Materials: L $ _____ R $ _____ | Extras: L $ _____ R $ _____ | Tax: L $ _____ R $ _____ |
|---|---|---|

3. CHARGE FOR FRAMES:
   Material:  $ _____   Extras: $ _____   TAX: $ _____

   INDIVIDUAL PRACTIONERS:   SS Number: _____ - _____ - _____

   ALL OTHERS:   Employer ID Number: _____ - _____

4. OPTICIAN AGENCY NAME: _____   SIGNATURE: _____