Vision Claim Form

Send all bills to:
Professional Benefit Administrators, Inc.
P.O. box 4687, Oak Brook, IL 60522
(800) 435-5694
Pbaclaims.com

INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

- The claim form must be fully completed.
- Sign and date Part A on the back of the form if you wish to have benefits paid directly to the Provider of Service.
- Part B, should be completed by the Provider of Service unless you have itemized bills. (Bills must show the patient's name, the date and type of service, the charge, the diagnosis, and the social security number or Federal Tax I.D. number of the provider).
- Return the completed form to the address shown above with all the original copies of your bills.

Complete for all claims

Company Name:	**Address:**	
Employee name:	**Date of birth:**	**ID#:**
Home Address:		**Phone:**
Sex: ☐ M ☐ F	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed	
Spouses Name:	**Date of birth:**	**ID#:**
Is Spouse Employed? ☐ Yes ☐ No	If yes, Company Name:	
Address:		**Phone:**

Are you or your dependents entitled to benefits from any other Group Insurance Plan or Group Vision Plan? ☐ Yes ☐ No If yes, please identify:	**A. Identify family member insured under other plan:**
	B. Name(s) and address of their insurance company and/or organization
	C. Group Policy Number

Complete if claim is for dependent

Company Name:	**Address:**	
Employee name:	**Date of birth:**	**ID#:**
Home Address:		**Phone:**
Sex: ☐ M ☐ F	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed	
Spouses Name:	**Date of birth:**	**ID#:**
Is Spouse Employed? ☐ Yes ☐ No	If yes, Company Name:	
Address:		**Phone:**

Are you or your dependents entitled to benefits from any other Group Insurance Plan or Group Vision Plan? ☐ Yes ☐ No If yes, please identify:	**A. Identify family member insured under other plan:**
	B. Name(s) and address of their insurance company and/or organization
	C. Group Policy Number

Part A – To be completed by the employee

Employee's Name:	**ID Number:**	**Patient's Name if Dependent of Employee:**
Employee's Address:		**Phone:**

AUTHORIZATION TO PAY BENEFITS TO PROVIDER OF SERVICE : I hereby authorize payment directly to the undersigned Provider of Service, the Vision Benefits, if any, otherwise payable to me, for the services as described below but not to exceed the reasonable and customary charge for those services.

Signed(employee): **Date:**

Part B – to be completed by the provider of service

Diagnosis and concurrent conditions: **Did you prescribe:** ☐ Yes ☐ No	**Date Service Began:** **Date Service Completed:**

REPORT OF SERIVCES (or attached itemized bill.)(if previous form submitted to PBA. You need show only date and services since last report.)

Date of Services			**Charges**
Prescribing			
	(a) Eye Examination	☐ With tonometry ☐ Without tonometry ☐ With visual fields ☐ Vision Survey	$
	(b) Prescribing Fee		$
Dispensing Fee			
	(a) Lenses	☐ Single ☐ Bifocal ☐ Trifocal ☐ Lenticular ☐ Tinted ☐ Temper ☐ List Other – i.e. sunglasses	$
	(b) Frame	☐ New ☐ Old Frame	$
Materials			
		☐ Lenses	$
		☐ Frames	$
		☐ Contacts	$
		☐ Other Materials or Services (List)	$

If Contact Lenses: ☐ Prescribed for a non-aphakic patient. ☐ In lieu of spectacles. ☐ Other, give reason:	**Total Charges**	$ 0.00
	Amount Paid	$ 0.00
	Balance Due	$ 0.00

Does patient have other health coverage:

☐ Yes ☐ No If yes, please identify:

I do not accept assignment ☐ Yes ☐ No	**Social Security No:** **OR Fed. ID No:**

Date **Physician's Name (Print)** **Signature**

☐ Ophthalmologist
☐ Optometrist
☐ Optician

Address:	**Phone:**