

VISION CLAIM FORM

ELECTRONIC PAYER ID NUMBER 95604

CHECK HERE IF THIS IS YOUR FIRST VISION CLAIM OR IF YOU HAVE MOVED SINCE YOUR LAST CLAIM

BEST Life and Health Insurance Company

P.O. Box 890

Meridian, ID 83890

800.433.0088 | Fax: 208.893.5040

IMPORTANT

Predetermination is required for all treatment plans in excess of the amount listed in the insurance policy. Refer to the Certificate of Insurance for predetermination requirements.

EMPLOYEE: Complete items 1 through 9 <input type="checkbox"/> Group Number 1 Employee name 3 Employee mailing address 6 Patient name 7 Relationship to employee 8 Spouse's date of birth 10 Doctor name 12 Doctor mailing address 15 Treatment result of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No 17 Result of occupational injury? <input type="checkbox"/> Yes <input type="checkbox"/> No I hereby authorize release of any information relating to this claim (Patient Signature) X _____ Date _____		DOCTOR: Complete items 10 through 24 SEND TO: BEST Life and Health Insurance Company P.O. Box 890 (949) 253-4080 Meridian, ID 83890 (800) 433-0088 2 Social security no. 4 Employer name 5 Is patient covered by other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter name of other plan 9 Patient's birthday Mo Day Year 11 License No. 13 Phone no. 14 Doctor soc. sec. no. or IRS taxpayers ID no. 16 VISION SERVICES NOT COVERED <ul style="list-style-type: none"> <input checked="" type="radio"/> Tinting <input checked="" type="radio"/> Oversized Lenses <input checked="" type="radio"/> Contact Lens Supplies <input checked="" type="radio"/> Service/Insurance Contracts <input checked="" type="radio"/> Plan/Prescription Sunglasses <input checked="" type="radio"/> Special Purpose Vision Aids This is a partial list. For complete list, see Certificate of Insurance and Exclusions.
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INFORMATION SECTION	DATE OF SERVICE	EXAM	PROFESSIONAL SERVICE PLEASE CHECK BOX	CHARGE	FOR Administrative USE ONLY
18 Complete visual analysis, including case history, refractions, etc.		E X A M	VISION ANALYSIS – M.D. <input type="checkbox"/> VISION ANALYSIS – O.D. <input type="checkbox"/>		
19 Is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for replacement		L E N S	SINGLE VISION ONE TWO <input type="checkbox"/> <input type="checkbox"/>		
20 Date of prior placement		S E R V I C E S	BIFOCAL <input type="checkbox"/> <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> <input type="checkbox"/> LENTICULAR <input type="checkbox"/> <input type="checkbox"/> Coverage is provided for replacement of existing lenses only when required by a change in prescription.		
Diagnosis		C O N T A C T	ONE CONTACT <input type="checkbox"/> TWO CONTACTS <input type="checkbox"/> Is visual acuity of the patient correctable to 20/70 in the better eye with conventional lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Can it be corrected to 20/70 or better by use of contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		
21 Are existing frames compatible with the new lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		L E N S E S	NEW FRAME <input type="checkbox"/> PATIENT'S FRAME <input type="checkbox"/>		
		F R A M E S			
			24 TOTAL FEE CHARGED		
22 I hereby certify that the services listed above have been performed (Doctor Signature) X _____ Date _____			23 I hereby authorize you to pay the above named doctor benefits due me under the terms of the vision plan. (EMPLOYEE SIGNATURE) X _____ Date _____		