

Antioch University
Group 10225

VISION CLAIM FORM

MedBen
Medical Benefits Company

EMPLOYEE INFORMATION

Employee's Name _____ Birthdate _____
First/Middle/Last

Social Security Number Male Female Single Married

Home Address _____
 Check if new address Street Address City State Zip

Home Phone _____ Cell Phone _____ Business Phone _____

Employee Work Status Active Retired _____ Terminated _____
 Layoff _____ Disabled _____
Date Last worked Date Last Worked Date Returned to Work

Are you enrolled in Medicare? Yes No If yes, attach explanation of Medicare Benefits

PATIENT INFORMATION (If patient is employee no need to fill in 8-10)

Patient's Name _____ Patient's Social Security No.

Relationship to Employee Self Spouse Child Stepchild Other (specify) _____

Birthdate _____ Male Female Single Married

Is the condition treated due to an accident? Yes No

If yes, date and time of accident _____ AM PM Was another person at fault Yes No

Describe how and where the accident occurred _____

FAMILY INFORMATION

Are any members of your family employed? Yes No If yes, complete the following:
Name: _____ Date of Birth: _____ Social Security No: _____ Employer Name and Address _____

Does employee or any family member have other vision insurance? Yes No
Name of family member (s) _____ Birthdate (s) _____

Type of Insurance Other Employer Sponsored Plan HMO Medicare No Fault Insurance
School Sponsored Plan Champus Other _____

Name & Address of Insurance Company or Administrator _____ Coverage Effective Date _____ Plan Number: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any Dentist, Physician, Health Professional, Supplier, Hospital, Pharmacy, Insurance company, Employer or Organization to release any information (including that related to mental illness) about myself and my descendants requested by Medical Benefit Administrators and it's consulting professionals, for the exclusive purpose of administering the provisions of Health Plan benefits to which I am entitled. This authorization shall extend to all services and claims and is valid for the term of coverage of the Health Plan benefits to which I am entitled. This authorization shall extend to all services and claims and is valid for the term of coverage of the Health Plan. A copy of this document shall be as valid as the original.

 Patient's or Authorized Person's Signature _____ Date _____

Warning: Anyone who intentionally includes false or misleading information in an attempt to defraud or deceive is guilty of a crime.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER SERVICES

I authorize payment to be made directly to the provider of the services covered by this claim form.

 Employee's Signature _____ Date _____

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PROVIDER TO COMPLETE

Enter change for each item as appropriate.

DATE OF EXAM	SINGLE VISION		BIFOCAL LENS		TRIFOCAL		CONTACTS		LENTICULAR		FRAMES	EXAM	SALES TAX
ACQUISITION COST													
DISPENSING FEE													
TABLE GRID													

If exam was performed on a different date, please give the date and name of provider who performed the examination: _____

Description of service: _____

Procedure Code: _____

PROVIDER NAME & ADDRESS:

Social Security No.

or

Taxpayer Identification No.

Name

Address

City

Phone Number

Provider Signature

Provider Specialty

Send completed form to:

MedBen

Medical Benefits Companies

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