

Part B. - Examining Physician or Optometrist's Information

Indicate diagnosis, nature of disease, injury or vision disorder

If contact lenses, would the visual acuity be corrected to 20/70 in the better eye by use of conventional lenses? yes no

Report of services or attach itemized bill. (If previous form submitted to this carrier, you need to show only dates and services since last report.)

Date of Service	Services Rendered	Charges
		\$
		\$
Physician's or optometrist's name		Phone number
		\$ Total charges
Physician's or optometrist's address (street, city, state, ZIP code)		Federal I.D. number or tax I.D. number
		\$ Amount paid
Physician's or optometrist's signature	Date	Your patient's account number
		\$ Balance due

Authorization to pay - Sign only if you want benefits paid directly to physician or optometrist.

I authorize payment of vision care benefits to the physician or optometrist described in Part B.

Employee or authorized person's signature _____ Date _____

Part C - Supplier Information (To be Completed by Dispenser of Prescription other than Prescribing Physician)

Type	Date of purchase	Date of delivery to patient	Charges	Supplier name and address (street, city, state, ZIP code)
Lenses				Supplier phone number
Frames				
Contacts				
Tint				
Coating				
Oversizing				
Other				
Type of lenses: <input type="checkbox"/> single vision <input type="checkbox"/> bifocal <input type="checkbox"/> trifocal <input type="checkbox"/> lenticular <input type="checkbox"/> contact lenses <input type="checkbox"/> disposable contact lenses number of months supplied: _____				Total charges \$ _____ Signature of supplier _____ Date _____ Patient's account number Amount paid Balance due _____ \$ _____ \$ _____

Authorization to pay - Sign only if you want benefits paid directly to supplier.

I authorize payment of vision care benefits to the supplier described in Part C.

Employee or authorized person's signature _____ Date _____

Payment receipt or cash register receipt for prescription attached (See item 5 below.)

Instructions to Employee

- Complete questions 1 through 17 (Part A) on Page 1 and sign and date line 17.
- Have patient's physician or optometrist complete the **Examining Physician or Optometrist's Information** section (Part B) on Page 2.
- Have patient's supplier (if other than examining physician or optometrist) complete the **Supplier Information** section (Part C) on Page 2.
- Attach itemized bills for expenses not shown on Page 1. If you want benefits paid directly to the physician or optometrist, sign the **Authorization to pay** in section (Part B) on Page 2. If you want benefits paid directly to the supplier (if other than examining physician or optometrist), sign the **Authorization to pay** in section (Part C) on Page 2.
- Attach payment receipt or cash register receipt to claim form if prescription is being filled by someone other than the examining physician or optometrist.