J.P. FARLEY CORPORATION

P.O. Box 458022 • Westlake, Ohio 44145
Toll Free 800-634-0173 • **Fax** 440-250-4301
benefits@JPFarley.com • **www.JPFarley.com**

VISION CLAIM FORM

Please send completed claim form to J.P. Farley's P.O. Box.

PART 1: EMPLOYEE'S STATEMENT

EMPLOYEE'S NAME *(Last)* *(First)*		EMPLOYEE SOCIAL SECURITY NO.
EMPLOYEE ☐ ACTIVE ☐ RETIRED	OCCUPATIONAL ILLNESS OR INJURY? ☐ YES ☐ NO	PATIENT'S NAME, IF CLAIM IS FOR DEPENDENT
EMPLOYER		

EMPLOYEE: Complete the applicable Items in Parts 1, 2 & 4.
Give the form to your Doctor to complete Part 3.
Have person filling prescription complete Part 5.
Return the completed form to the above address.

PART 2:

ITEM 1: COMPLETE FOR ALL CLAIMS

THIS CLAIM IS FOR	IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS
☐ MALE EMPLOYEE ☐ FEMALE EMPLOYEE ☐ SPOUSE ☐ CHILD DATE OF BIRTH OF THIS PERSON _____	☐ YES ☐ NO

EMPLOYEE'S NAME	EMPLOYEE'S ADDRESS *(No., Street, City, State, Zip Code)*
GIVE NATURE OF ILLNESS OR INJURY	IF CLAIM IS DUE TO ACCIDENT, STATE WHEN, WHERE AND HOW IT OCCURRED

ARE YOU ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ SEPARATED	DO YOU HAVE MORE THAN ONE EMPLOYER ☐ YES ☐ NO	NAME AND ADDRESS OF OTHER EMPLOYER

ITEM 2: COMPLETE IF YOUR ARE MARRIED

NAME OF SPOUSE	SPOUSE'S SOCIAL SECURITY NUMBER
IS YOUR SPOUSE EMPLOYED (IF "YES" NAME AND ADDRESS OF SPOUSE'S EMPLOYER)	EMPLOYER'S PHONE NUMBER
DOES YOUR SPOUSE HAVE OTHER GROUP VISION COVERAGE ☐ YES ☐ NO	NAME OF SPOUSE'S GROUP VISION BENEFIT CARRIER (OTHER THAN THIS PLAN)

ITEM 3: COMPLETE IF CLAIM IS FOR YOUR DEPENDENT OTHER THAN SPOUSE

NAME OF DEPENDENT	IF DEPENDENT CHILD OVER AGE 19, INDICATE ☐ HANDICAPPED ☐ STUDENT (GIVE NAME OF SCHOOL) _____
IS THIS DEPENDENT EMPLOYED (IF "YES", NAME AND ADDRESS OF EMPLOYER) ☐ YES ☐ NO	EMPLOYER'S PHONE NUMBER
DOES DEPENDENT HAVE OTHER GROUP VISION COVERAGE ☐ YES ☐ NO	NAME OF DEPENDENT'S GROUP VISION BENEFIT CARRIER

ITEM 4: COMPLETE FOR ALL CLAIMS

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Health Plan to release or obtain any information which may be necessary to determine benefits payable under the group plan.

A photostatic copy of this authorization shall be considered as effective and valid as the original.
I hereby certify the statements hereon are complete and accurate to the best of my knowledge.

Signed (Employee) _____ **Date** _____

HEALTH CLAIM — VISION CARE

PART 2: (Continued) TO BE COMPLETED BY EMPLOYEE

PATIENT'S NAME

AUTHORIZATION TO PAY: I hereby authorize payment directly to the undersigned Doctor of the Vision Care 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

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment. ▶ SIGNED (PATIENT, OR PARENT IF MINOR) DATE

PART 3: EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST'S STATEMENT

DIAGNOSIS ON NATURE OF DISEASE, INJURY OR VISION DISORDER

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT

☐ YES ☐ NO *If yes, explain*

REPORT OF SERVICES *(Or attach itemized bill)*

Date of Services	Services Rendered	Charges

TOTAL CHARGES ▶ _____ BALANCE DUE ▼

AMOUNT PAID ▶ _____ _____

Did patient have glasses prior to this examination

☐ YES ☐ NO IF YES, WHAT TYPE? ☐ CONVENTIONAL ☐ CONTACTS

DOES PATIENT REQUIRE A LENS PRESCRIPTION CHANGE AT THIS TIME? ARE NEW FRAMES REQUIRED?

☐ YES ☐ NO *If Yes, why?* ☐ YES ☐ NO

MATERIALS PRESCRIBED *(Check appropriate box(es) and indicate number prescribed)*

☐ FRAMES _____ ☐ BIFOCAL _____ ☐ CONTACT LENSES _____

☐ SINGLE VISION _____ ☐ TRIFOCAL _____ ☐ OTHER _____

IF TINTED LENSES, SUNGLASSES AND/OR SAFETY GLASSES PRESCRIBED, PLEASE EXPLAIN

DOES PATIENT HAVE OTHER HEALTH COVERAGE

☐ YES ☐ NO *If Yes, please identify*

DATE | TYPE OR PRINT FULL NAME | DEGREE

PHYSICIAN'S SIGNATURE | TELEPHONE

INDIVIDUAL PRACTITIONERS-SS # | | | |

ALL OTHERS - EMPLOYER I.D. # | | |

MUST BE FURNISHED UNDER AUTHORITY OF LAW

STREET ADDRESS | CITY OR TOWN | STATE | ZIP CODE

PART 4: TO BE COMPLETED BY EMPLOYEE

AUTHORIZATION TO PAY: I hereby authorize payment directly to the undersigned Doctor of the Vision Care 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 5: TO BE COMPLETED BY DISPENSER OF PRESCRIPTION (OR ATTACH ITEMIZED STATEMENT)

DATE DISPENSED | FEE FOR: LENSES $_____ FRAMES $_____ CONTACTS $_____

TYPE OR PRINT FULL NAME | TITLE

PHYSICIAN'S SIGNATURE | TELEPHONE

INDIVIDUAL PRACTITIONERS-SS # | | | |

ALL OTHERS - EMPLOYER I.D. # | | |

MUST BE FURNISHED UNDER AUTHORITY OF LAW

STREET ADDRESS | CITY OR TOWN | STATE | ZIP CODE

PHYSICIAN RETURNS THIS FORM TO:
THE J.P. FARLEY CORPORATION, P.O. Box 458022, Westlake, OH 44145-8022