

## **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)		(First)		EMPLOYEE SOCIAL SECURITY NO.		
EMPLOYEE	OCCUPATIONAL ILLNESS C	R INJURY? PATIE	T'S NAME, IF CLAIM IS FOR DEF	PENDENT		
		e				
EMPLOYER	L					
EMPLOYE	Give the form to Have person fill	your Doctor	is in Parts 1, 2 & 4. to complete Part 3. on complete Part 5. o the above address.			
PART 2: ITEM 1: COMPLETE FOR A						
THIS CLAIM IS FOR	LL VLAIMO	Can but also anyon			IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS	
			DATE OF BIRTH OF THIS PERSON	<u></u>		
EMPLOYEE'S NAME		EMPLOYEE'S ADD	ESS (No., Street, City, State, Zip	Code)		
GIVE NATURE OF ILLNESS OR INJU	IRY		IF CLAIM IS DUE TO ACCIDENT, STATE WHEN, WHERE AND HOW IT OCCURRED			
ARE YOU SINGLE DIVORCED DO YOU HAVE MORE THAN ONE			YER NAME AND ADDRESS (	OF OTHER EMPLOYER		
ITEM 2: COMPLETE IF YOU	R ARE MARRIED					
NAME OF SPOUSE			SPOUSE'S SOCIAL SECURITY	YNUMBER		
IS YOUR SPOUSE EMPLOYED (IF "Y	YES" NAME AND ADDRESS OF SPO	DUSE'S EMPLOYER)	I	EMPLOYE	R'S PHONE NUMBER	
DOES YOUR SPOUSE HAVE OTHER	GROUP VISION COVERAGE	NAME	OF SPOUSE'S GROUP VISION BE	NEFIT CARRIER (OTHER THA	N THIS PLAN)	
I YES INO						
TEM 3: COMPLETE IF CLAI	IM IS FOR YOUR DEPEND	ENT OTHER TH	A second s			
NAME OF DEPENDENT						
IS THIS DEPENDENT EMPLOYED (IF	"YES", NAME AND ADDRESS OF	EMPLOYER)		EMPLOYER'S PHOP	NE NUMBER	
DOES DEPENDENT HAVE OTHER GROUP VISION COVERAGE			IE OF DEPENDENT'S GROUP VISION BENEFIT CARRIER			
YES NO						
TEM 4: COMPLETE FOR AL	L 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.

## HEALTH CLAIM - VISION CARE

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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.	PART 2: (Continued)	) T	O BE COMPLETED	BY EMPLOYEE		
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Did patient have glasses pror to this examination          Image: the problem of the sexamination       IF YES, WHAT TYPE?       CONVENTIONAL       CONTACTS         DOES PATIENT RECURRE A LENS PRESCRIPTION CHANGE AT THIS TIME?       ARE NEW PRAMES REQUIRED?       YES       NO         MATERIALS PRESCRIBED (Check appropriate bod/est and indicate number prescribed)       Image: the						•
Image: Second	N/ 2346-7			AMOUNT PAID		
DOES PATIENT REQUIRE A LENS PRESCRIPTION CHANGE AT THIS TIME?       ARE NEW FRAMES REQUIRED?         Image: Ima			YES WHAT TYPE?			q
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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       ALL OTHERS - EMPLOYER ID. #         MUST BE FURNISHED UNDER AUTHORITY OF LAW       STATE       ZIP CODE         PART 4:       TO BE COMPLETED BY EMPLOYEE       SKONED (EMPLOYEE)         AUTHORIZATION TO PAY: I hereby authorize payment directly to the varies and school below but not to exceed payment directly to the services       SKONED (EMPLOYEE)         PART 5:       TO BE COMPLETED BY DISPENSER OF PRESCRIPTION (OR ATTACH ITEMIZED STATEMENT)         DATE DISPENSED       FEA FOR:       CONTACTS \$         TYPE OR PRINT FULL NAME       TITLE       INDIVIDUAL PRACTITIONERS-SS #         TYPE OR PRINT FULL NAME       TITLE       INDIVIDUAL PRACTITIONERS-SS #         PHYSICIAN'S SIGNATURE       TITLE       INDIVIDUAL PRACTITIONERS-SS #						
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PHYSICIAN RETURNS THIS FORM TO: THE J.P. FARLEY CORPORATION, P.O. Box 458022, Westlake, OH 44145-8022