Allied Benefit Systems, Inc.
P.O. Box 211651
Eagan, MN 55121
Phone: (800) 288-2078
Fax: (312) 906-8359

Vision Claim Form

Please complete the applicable items in Part 1 and give the form your Provider and Dispenser to complete Parts 2 and 3. Please return the completed form to Allied Benefit Systems Inc. Please submit an itemized bill along with this claim form.

Part 1: To be completed by Employee/Patient

Employer Information

Employer Name	Group Number

Employee Information

Employee Name	Social Security Number	Birthdate	
Employee Address	**City**	**State**	**Zip**

Do you or any of your dependents have other group vision coverage?

[ ] Yes (please provide information below) [ ] No

Name of Individual with other coverage	Other Insurance Carrier or TPA		
Address of Carrier or TPA	**City**	**State**	**Zip**

Patient Information

Patient Name	Gender	Birthdate

Relationship to Employee

[ ] Self [ ] Spouse [ ] Child [ ] Other:

Claim Information

Was this claim due to an accident?	If yes, what was the date of the accident?
[ ] Yes [ ] No	
Where did the accident occur?	**Is this claim the result of a work related illness or injury?**
	[ ] Yes [ ] No

Provider Information

Provider Name	Patient Name	Date of Service	Total Charge

Employee Authorization

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of vision treatment.

Employee Signature Date

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the provider of vision services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.

Employee Signature Date

Part 2: To be completed by doctor, examining ophthalmologist or optometrist

Diagnosis or nature of disease, injury or vision disorder	Is condition due to patient's employment? [ ] Yes [ ] No
If yes, please explain	

Did the patient have glasses prior to examination [ ] Yes [ ] No	If yes, what type? [ ] Conventional [ ] Contacts
Does the patient require a lens prescription change? [ ] Yes [ ] No	If yes, please explain

Materials prescribed (please check all that apply) and indicate the number prescribed:

[ ] Frames: _____ [ ] Single Vision: _____ [ ] Bifocal: _____ [ ] Trifocal: _____ [ ] Contacts: _____ [ ] Other: _____

If prescribing tinted lenses, sunglasses, and/or safety glasses, please explain why:

Report of Services (or attach itemized bill)

Provider Name	Provider Tax ID	Date of Service	Description of Service	Patient Name

Total Charge	$
Total Patient Paid	$
Total Reimbursement Request	$

Part 3: To be completed by dispenser of prescription (or attach itemized statement)

Date of Delivery	Fee for Lenses	Fee for Frames	Fee for Contacts
	$	$	$

Full Name	Degree	Telephone Number	
Address	City	State	Zip

Dispenser Signature _____ Date _____

THE FOLLOWING MUST BE FURNISHED UNDER AUTHORITY OF LAW

Individual Practitioners SSN	All Others Federal Tax ID Number

Part 4 - Additional Comments