CLAIM INSTRUCTIONS

EMPLOYEE:

- Use this form to obtain reimbursement for services.
- Complete the employee section of the form.
- Sign and date the form after checking for completeness.
- Attach copy of itemized receipts.
- Submit the form to:

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187
CLIFTON, NEW JERSEY 07015
TOLL FREE 800-672-7723

If you have any questions, please contact NVA at 800-672-7723.

CLAIM FOR VISION CARE EXPENSE

FOR NON-PARTICIPATING PROVIDERS

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
800-672-7723

TO BE COMPLETED BY EMPLOYEE (*Print*)

LAST NAME FIRST

CARD MEMBER SOC SEC NUM ___ ___ ___ – ___ ___ – ___ ___ ___ ___

STREET ADDRESS

FIRST NAME	DATE OF BIRTH	GENDER	STATUS
	/ /	MALE ☐ FEMALE ☐	SPOUSE ☐ CHILD ☐

CITY STATE ZIP CODE

SPONSOR NAME
University of Delaware
Group # 51942

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

I HEREBY CERTIFY THAT THE PATIENT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FOR THE BENEFITS AND THAT I HAVE RECEIVED THE SERVICES DESCRIBED. I ALSO CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN ON THE JOB INJURY OR COVERED UNDER ANOTHER VISION PROGRAM. I FURTHER AUTHORIZE THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITER, SPONSOR, POLICY HOLDER AND THE EMPLOYER.

EMPLOYEE'S SIGNATURE _____ DATE _____

IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? ☐ YES ☐ NO 2) SAFETY GLASSES? ☐ YES ☐ NO 3) CATARACT SURGERY? ☐ YES ☐ NO IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN THE SPACE PROVIDED.

IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? ☐ YES ☐ NO IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE SPACE PROVIDED.

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST (*Print*)

EXAMINER NAME ☐ MD ☐ OD TAX ID#

PATIENT NAME DATE OF EXAM

STREET ADDRESS

CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL EYEGLASSES? ☐ YES ☐ NO

CITY STATE ZIP CODE

DOES PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? ☐ YES ☐ NO

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.

SIGNATURE_____DATE_____

DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? ☐ YES ☐ NO IF YES, CHANGES:

AXIS_____SPHERE/CYLINDER_____

SERVICE CHARGE

$

I HAVE PRESCRIBED: ☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ APHAKIC CONTACTS: ☐ HARD ☐ SOFT ☐ COSMETIC ☐ MEDICALLY REQUIRED

TO BE COMPLETED BY DISPENSER (*Print*)

DISPENSER NAME TAX ID#

PATIENT NAME DATE OF SERVICE

STREET ADDRESS

CITY STATE ZIP CODE

Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD
RIGHT					
LEFT					

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.

SIGNATURE_____DATE_____

LENSES

U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE

TRADE NAME WIDTH ☐ PAIR ☐ ONE ☐ GLASS ☐ PLASTIC

FRAMES

MANUFACTURER NAME SIZE MODEL OR STYLE

FRAME NUMBER ☐ PLASTIC ☐ METAL ☐ COMBINATION ☐ NEW ☐ PATIENT'S

MATERIALS SUPPLIED	CHARGES	NVA USE
☐ SINGLE VISION		
☐ BIFOCAL		
☐ TRIFOCAL		
☐ APHAKIC		
☐ CONTACTS ☐ HARD ☐ SOFT		
☐ TINT #_____ COLOR_____		
☐ OTHER _____		
FRAME		
TOTAL CHARGE		