VISION CLAIM FORM

PLEASE COMPLETE ONE CLAIM FORM PER PATIENT

1. Complete all questions

Check here if new address ☐

A. Employer Information

Name of Your Employer

Group number as shown on your ID Card

B. Employee Information

Last Name First Name MI

Employee's Social Security Number

Home Address

Employee's Birth Date

Month Day YR

City State Zip

Marital Status Single ☐ Married ☐ Divorced ☐

C. Patient Information

Last Name First Name MI

Relationship to Employee

Self ☐ Spouse ☐ Child ☐

Patient's Birth Date

Month Day YR

If over 19, is child a full-time student? Yes ☐ No ☐
If yes, School attended:

Is Patient employed? Yes ☐ No ☐
If Yes, Name of Employer:

Is Spouse employed? Yes ☐ No ☐
If Yes, Name of Employer:

Does Employer offer Group Vision Plan? Yes ☐ No ☐

Does Employer offer Group Vision Plan? Yes ☐ No ☐

2. Complete the sections which apply to your claim

D. Complete if Patient is covered under any other vision plan

Other Group Plan Name

Identification / Policy Number

Insurance Company Name and Address

City State Zip

E. Complete if services are the result of an accident

Is claim due to an accident?
Yes ☐ No ☐

If "yes," where did the accident occur?

Date of accident

Month Day YR

Describe Accident

Is this claim the result of a work-related illness or injury? Yes ☐ No ☐

3. Assignment of Benefits

F. Complete only if you wish payment to be made directly to the provider of service

Name of Vision Service Provider

City State Zip

Phone No.
( )

Provider's I.D. No.

Employee's Signature Authorizing Assignment of Benefits

Date

Month Day YR

4. Must be signed and dated by the Employee

G. Read and complete authorization to release medical and insurance information

To any physician, medical practitioner, hospital, clinic or other medically-related facility or provider of medical services or supplies, and any employer, group policyholder, or contract holder or insurer, I authorize you to release to TRISTAR Benefit Administrators, Inc. or to its representatives any and all information you may have about the mental and physical history, condition and treatment, and insurance coverage for the Patient named in Section C above.

I understand the information obtained by TRISTAR Benefit Administrators will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by TRISTAR Benefit Administrators to any person or organization EXCEPT to reinsuring companies, Group Policyholder, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required or as I may further authorize. For the purpose of disclosing information, I understand that this authorization is valid for a period of one year. I know that I may request a copy of this authorization. If this authorization is given in connection with a claim for health benefit, disability or life insurance benefits, I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original.

Employee's Signature

Date

Month Day YR

PROVIDER MUST COMPLETE THE REVERSE SIDE.

Please send the completed claim form and appropriate statements to:

TRISTAR Benefit Administrators
P.O. Box 65887
West Des Moines, IA 50265

TO BE COMPLETED BY PROVIDER OF VISION SERVICES

PROVIDER OF SERVICE

Date of Service	Place of Service	Type of Service	Fully describe procedures, vision services, or supplies furnished for each date given. (Explain unusual services or circumstances)	Charges	

Signature of Physician or Supplier Signed Date	Accept Assignment Yes ☐ No ☐	Total Charge	Balance Due
	Employer SS Number or	Physician's or Supplier's Name, Address, Zip Code, and Telephone No.	
Patient Account Number	Employer T.I.N. Number	I.D. No.	

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