PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

Subscriber ID from Card, or SS Number

Name of Patient

Responsible Member's Name

Address of Patient

Complete only if different than the Patient

Patient's City and State

Patient ID Number, if known

Company Name for Subscriber

Plan ID From Card

ECPA or EyeMed Plan from Card

Patient must acknowledge services

For Exams, Please include primary and secondary diagnosis. A Refractive diagnosis must be included.

Authorization issued by EyeMed

Date of service

Please Use attached list of acceptable codes.

4 digit modifiers and valid HCPCS and CPT codes only

Two digit Modifiers only

Please indicate all charges and what the member paid out of pocket to eliminate processing delays. This will also eliminate communication to provider/ member to collect or refund from the patient. Copays should be in Amount Paid and not under services.

Tax ID of Service Location

Include 6 Character Primary Provider / Location Identifier (ie 112123 01, GA1234 02, CP1234

Include 6 character EyeMed Servicing Provider Identifier (112111, GA9876)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 12345678-01

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patricia E. Doe

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): John K. Doe

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

6. PATIENT RELATIONSHIP TO INSURED: self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Cincinnati | STATE: OH

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 45242 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 12345678

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: Luxottica MFG

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: 9645235

d. INSURANCE PLAN NAME OR PROGRAM NAME: EyeMed Plus Plan

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Patient must acknowledge services | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 367.1
2. 365.0
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER: 2030821173

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
10/15/03				92004			40.00					"Comprehensive Exam"
10/15/03				V2025			175.00					"Luxottica Frame"
10/15/03				V2319	V1		95.00					"Flat Top 35 Trifocal"
10/15/03				V2755			95.00					"Ultra violet Protection"
10/15/03				S0580			45.00					"Polycarbonate Lens"
10/15/03				S0500			18.00					"Disposable Contacts" Planned Replacement

25. FEDERAL TAX I.D. NUMBER: 31-99565626 | SSN | EIN

26. PATIENT'S ACCOUNT NO

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ 468.00 | $ 165.00 | $ 303.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Eye Care
1234 S. Main
Cincinnati OH 45222
EyeMed ID 112333 or CA1124

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Jim Smith
PF # CA1234 or 112333

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION