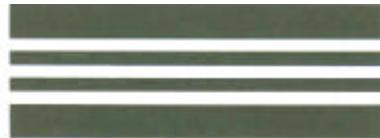


PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	2. MEDICAID (Medicaid #)	3. CHAMPUS (Sponsor's SSN)	4. CHAMPVA (VA File #)	5. GROUP HEALTH PLAN (SSN or ID)	6. FECA BLK LUNG (SSN)	7. OTHER (ID)	8. INSURED'S ID NUMBER Subscriber ID from Card, or SS Number	9. FOR PROGRAM IN ITEM 1 PICA <input type="checkbox"/> <input type="checkbox"/>								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Name of Patient			3. PATIENT'S BIRTH DATE DD / YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) Responsible Member's Name									
5. PATIENT'S ADDRESS (No., Street) Address of Patient			6. PATIENT RELATIONSHIP TO INSURED Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) Complete only if different than the Patient										
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		CITY		STATE								
ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER Patient ID Number, if known								
b. OTHER INSURED'S DATE OF BIRTH MM / DD / YY		M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM / DD / YY								
c. EMPLOYER'S NAME OR SCHOOL NAME		d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 and		d. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (authorize payment of medical benefits to the undersigned physician or supplier for services described below)		SEX M <input type="checkbox"/> F <input type="checkbox"/>								
e. INSURANCE PLAN NAME OR PROGRAM NAME ECPA or EyeMed Plan from Card		f. RESERVED FOR LOCAL USE		g. SIGNED		h. SIGNED										
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.																
Patient must acknowledge services																
SIGNED		DATE														
14. DATE OF CURRENT 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 FROM MM / DD / YY TO MM / DD / YY		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM / DD / YY TO MM / DD / YY										
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/>		19. RESERVED FOR LOCAL USE										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER Authorization issued by EyeMed		24. A DATE(S) OF SERVICE From MM / DD / YY To MM / DD / YY		25. B Place of Service	26. C F PROCEDURES, SERVICES, OR SUPPLIES EXPLAIN UNUSUAL CIRCUMSTANCES CPT/HCPCS MODIFIER	27. D DIAGNOSIS CODE	28. E CHARGES	29. F DAYS ON UNITS	30. G EPSDT Family Plan	31. H EMG	32. I COB	33. J RESERVED FOR LOCAL USE
1. For Exams, Please include primary and secondary diagnosis. A Refractive diagnosis must be included.		2. Please Use attached list of acceptable codes.		3. 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.		4. Date of service		5. 4 digit modifiers and valid HCPCS and CPT codes only		6. Two digit Modifiers only		7. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33.				
25. FEDERAL TAX ID NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? IF NO, GIVE CLAIMS FILE NUMBER YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$		31. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
Tax ID of Service Location INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and the amounts when remitted.)		32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		34. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		35. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		36. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		37. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
38. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		39. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		40. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		41. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		42. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		43. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		44. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
45. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		46. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		47. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		48. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		49. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		50. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		51. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
52. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		53. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		54. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		55. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		56. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		57. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		58. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
59. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		60. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		61. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		62. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		63. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		64. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		65. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
66. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		67. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		68. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		69. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		70. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		71. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		72. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
73. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		74. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		75. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		76. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		77. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		78. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		79. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
80. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		81. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		82. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		83. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		84. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		85. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		86. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
87. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		88. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		89. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		90. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		91. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		92. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		93. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
94. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		95. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		96. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		97. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		98. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		99. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		100. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				

PATIENT AND INSURED INFORMATION

CARRIER

PATIENT OR SUPPLIER INFORMATION

PLEASE
DO NOT
STAPLE
IN THIS
AREA



HEALTH INSURANCE CLAIM FORM

PICA (FOR PROGRAM IN ITEM 1)

1. PICA		2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
1. MEDICARE <input type="checkbox"/> (Medicare #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA Fee #)		2. PATIENT'S ADDRESS (No., Street)		MM <input type="checkbox"/> DD <input type="checkbox"/> YY	SEX <input type="checkbox"/> M <input type="checkbox"/> F	5. INSURED'S ADDRESS (No., Street)					
Patricia E. Doe		123 Main Street		6. PATIENT RELATIONSHIP TO INSURED		6. PATIENT STATUS					
CITY Cincinnati		STATE OH	7. PATIENT'S STATUS		Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY STATE					
ZIP CODE 45242		TELEPHONE (INCLUDE AREA CODE) ()	Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Student <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		ZIP CODE ()	TELEPHONE (INCLUDE AREA CODE) ()					
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		9. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER					
				a. EMPLOYMENT? (CURRENT OR PREVIOUS)		12345678					
				YES <input type="checkbox"/> NO <input type="checkbox"/>	b. AUTO ACCIDENT?		a. INSURED'S DATE OF BIRTH				
				YES <input type="checkbox"/> NO <input type="checkbox"/>	PLACE (Sub) _____		MM <input type="checkbox"/> DD <input type="checkbox"/> YY	SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>			
				YES <input type="checkbox"/> NO <input type="checkbox"/>	c. OTHER ACCIDENT?		b. EMPLOYER'S NAME OR SCHOOL NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME		13. RESERVED FOR LOCAL USE		d. INSURANCE PLAN NAME OR PROGRAM NAME		Luxottica MFG					
EyeMed Plus Plan				14. RESERVED FOR LOCAL USE		9645235					
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.											
Patient must acknowledge services											
SIGNED _____ DATE _____		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION							
16. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. ID NUMBER OF REFERRING PHYSICIAN		FROM MM DD YY TO MM DD YY							
18. RESERVED FOR LOCAL USE		17b. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		FROM MM DD YY TO MM DD YY							
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		20. OUTSIDE LAB?		\$ CHARGES							
1. 367.1		YES <input type="checkbox"/> NO <input type="checkbox"/>		21. MEDICAID RESUBMISSION CODE							
2. 365.0		22. PRIOR AUTHORIZATION NUMBER		ORIGINAL REF. NO.							
24. A. DATE(S) OF SERVICE		B. FROM MM DD YY	C. TO MM DD YY	D. DATES OF SERVICE	E. PROCEDURES, SERVICES OR SUPPLIES (Explain Unique Circumstances) CPT/HCPCS	F. CHARGES	G. DAYS OF SUPPLY UNITS	H. EPSCD Supply 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 ID NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (If Govt. Contracts with Doctor)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
31-99565626				YES <input type="checkbox"/> NO <input type="checkbox"/>		\$ 468.00		\$ 165.00		\$ 303.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse side of this bill are accurate and true)								32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			
								Eye Care 1234 S. Main Cincinnati OH 45222 EveMed 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