GROUP VISION CLAIM FORM

Third Party Administrators

SUBMIT CLAIMS TO: P.O. BOX 45018, FRESNO, CA (800) 442-7247

1. Your Policy and/or Group number(s)

Group # D70

2. Name and address of employer

Eskaton 5105 Manzanita Ave, Carmichael, CA 95608

EMPLOYEE INFORMATION

3. Name of employee *(insured)* | ☐ Male ☐ Female | **Date of Birth** | ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

4. Address of employee Street City State Zip Code | **5. Employee's Social Security number**

6. Other Vision Insurance Coverage? ☐ Yes ☐ No **If yes, please provide name of employer and address of Insurance Company**

IF CLAIM FOR DEPENDENT, COMPLETE THIS SECTION ALSO

7. Name of your dependent | ☐ Male ☐ Female | **Date of Birth** | **Is dependent a full-time student?** ☐ Yes ☐ No

COMPLETE FOR VISION SERVICES OR ATTACH ITEMIZED BILL

8. Date of Service	Services Rendered	Charge

9. Physician or Optometrist Name | **Address** Street City State Zip Code

10. Tax ID Number | **11. Signature of Physician or Optometrist** | **Date Signed**

COMPLETE FOR VISION SUPPLIES OR ATTACH ITEMIZED BILL

12. LENSES: ☐ One Eye ☐ Both Eyes

Charge:_____ ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Other _____

13. FRAMES:

Charge:_____

14. Are existing Frames being used for new lenses? ☐ Yes ☐ No

If No, Why?

15. Suppliers Name | **Address** Street City State Zip Code

16. Tax ID Number | **17. Signature of Supplier** | **Date Signed**

IMPORTANT – PLEASE COMPLETE AUTHORIZATION SECTION

18. AUTHORIZATION TO RELEASE INFORMATION:

The above answers are true and correct to the best of my knowledge. I hereby authorized any physician, surgeon, practitioner or other person, any hospital, including veterans administration or government hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A Photostat of this authorization shall be as valid as the original.

Signed (Patient or Parent if Minor) **Date**

19. AUTHORIZATION TO PAY INSURANCE BENEFITS:

I hereby authorize payment directly to the Physician named above those benefits otherwise payable to me but not to exceed the Physician's regular charges. I understand I am financially responsible to the Physician for charges not covered by this authorization.

Signed (Patient or Parent if Minor) **Date**

Please attach itemized bills to this form and mail to : HEALTHCOMP, INC.