Fringe Benefit Services Inc.

VISION CLAIM FORM

P.O. Box 670 • 79 Connelly Boulevard • Sharon, Pennsylvania 16146
Phone (724) 981-3300 or (800) 732-9281 • Fax (724) 981-4041

1. Patient Name first m.i. last	2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other _____	3. Sex m | f	4. Patient birthdate MM | DD | YYYY	5. If full time student school city

6. Employee/Subscriber name and mailing address	7. Employee/Subscriber soc.sec. number	8. Employee/Subscriber birthdate MM | DD | YYYY	9. Employer(company) name & address	10. Group number

11. Is patient covered by another plan of benefits? Vision _____ Medical _____	12a. Name and address of carrier(s)	12b. Group number(s)	13. Name & address of employer

14a. Employee/Subscriber name (If different than patient's)	14b. Employee/Subscriber soc. sec. number	14c. Employee/Subscriber birthdate MM | DD | YYYY	15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other _____

16. Provider	21. Is treatment result of occupational illness or injury?	No	Yes	If Yes, enter brief description and dates.
17. Mailing address	22. Is treatment result of auto accident?			
	23. Other accident?			
City, State, Zip	24. Are any services covered by another plan?			

18. Soc. Sec. Number or T.I.N. 19. License number 20. Phone number

25. Diagnosis or nature or illness or injury.

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26. Date of service or receipt	Place of service	Procedure code	Fully describe procedures, medical services or supplies furnished for each date given. (Explain unusual services or circumstances)	Charges

Has the patient's prescription changed by an axis of 20 degrees or a .50 diopter sphere or cylinder change and the new lenses improve the Plan Member's visual acuity by at least one line on the standard eye chart. ____ No ____ Yes

Total Charges

Amount Paid

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees that I have charged and intend to collect for those procedures.

Signed (Provider) Date

Signed (Insured person) Date