

CLAIM INSTRUCTIONS

EMPLOYEE:

- Use this form to obtain reimbursement for services.
- Complete the employee section of the form.
- Sign and date the form after checking for completeness.
- Attach copy of itemized receipts.
- Submit the form to:

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187
CLIFTON, NEW JERSEY 07015
TOLL FREE 800-672-7723

If you have any questions, please contact NVA at 800-672-7723.

CLAIM FOR VISION CARE EXPENSE FOR NON-PARTICIPATING PROVIDERS



NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
800-672-7723

TO BE COMPLETED BY EMPLOYEE (Print)

LAST NAME		FIRST		CARD MEMBER							
STREET ADDRESS		FIRST NAME		DATE OF BIRTH		GENDER		STATUS			
				/ /		MALE ☐ FEMALE ☐		SPOUSE ☐ CHILD ☐			
CITY	STATE	ZIP CODE		SPONSOR NAME			MARITAL STATUS				
							☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED				
I HEREBY CERTIFY THAT THE PATIENT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FOR THE BENEFITS AND THAT I HAVE RECEIVED THE SERVICES DESCRIBED. I ALSO CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN ON THE JOB INJURY OR COVERED UNDER ANOTHER VISION PROGRAM. I FURTHER AUTHORIZE THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITER, SPONSOR, POLICY HOLDER AND THE EMPLOYER.											
EMPLOYEE'S SIGNATURE _____										DATE _____	
IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? ☐ YES ☐ NO 2) SAFETY GLASSES? ☐ YES ☐ NO 3) CATARACT SURGERY? ☐ YES ☐ NO IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN THE SPACE PROVIDED.											
IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? ☐ YES ☐ NO IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE SPACE PROVIDED.											

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST (Print)

EXAMINER NAME	☐ MD ☐ OD	TAX ID#	PATIENT NAME	DATE OF EXAM
STREET ADDRESS			CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL EYEGLASSES? ☐ YES ☐ NO	
CITY	STATE	ZIP CODE	DOES PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? ☐ YES ☐ NO	
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.			DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? ☐ YES ☐ NO IF YES, CHANGES:	
SIGNATURE _____ DATE _____			AXIS _____ SPHERE/CYLINDER _____	SERVICE CHARGE \$ _____
I HAVE PRESCRIBED: ☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ APHAKIC CONTACTS: ☐ HARD ☐ SOFT ☐ COSMETIC ☐ MEDICALLY REQUIRED				

TO BE COMPLETED BY DISPENSER (Print)

DISPENSER NAME		TAX ID#		PATIENT NAME			DATE OF SERVICE	
STREET ADDRESS				Rx	SPHERE	CYLINDER	AXIS	PRISM
CITY				RIGHT				ADD
STATE				LEFT				
ZIP CODE				MATERIALS SUPPLIED		CHARGES		NVA USE
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.				☐ SINGLE VISION				
				☐ BIFOCAL				
				☐ TRIFOCAL				
				☐ APHAKIC				
				☐ CONTACTS				
				☐ HARD ☐ SOFT				
				☐ TINT # _____ COLOR _____				
				☐ OTHER _____				
SIGNATURE _____ DATE _____				FRAME				
L E N S E S				U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE				
TRADE NAME				WIDTH	☐ PAIR ☐ ONE			
				☐ GLASS ☐ PLASTIC				
F R A M E S				MANUFACTURER NAME		SIZE	MODEL OR STYLE	
				FRAME NUMBER		☐ PLASTIC ☐ METAL ☐ NEW		
				☐ COMBINATION ☐ PATIENT'S				
				TOTAL CHARGE				