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)

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>CARD MEMBER</th>
<th>SOC SEC NUM</th>
<th>FIRST NAME</th>
<th>DATE OF BIRTH</th>
<th>GENDER</th>
<th>STATUS</th>
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<tr>
<th>STREET ADDRESS</th>
<th>ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
<th>SPONSOR NAME</th>
<th>MARITAL STATUS</th>
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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)

<table>
<thead>
<tr>
<th>EXAMINER NAME</th>
<th>MD</th>
<th>TAX ID#</th>
<th>PATIENT NAME</th>
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<th>STREET ADDRESS</th>
<th>EXAMINATION</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
<th>DOES PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? □ YES □ NO</th>
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I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.

SIGNATURE __________________________ DATE __________________

DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? □ YES □ NO
IF YES, CHANGES:
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)

<table>
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<tr>
<th>DISPENSER NAME</th>
<th>TAX ID#</th>
<th>PATIENT NAME</th>
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I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.

SIGNATURE __________________________ DATE __________________

U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE

TRADE NAME  WIDTH  □ PAIR □ ONE  □ GLASS □ PLASTIC

MANUFACTURER NAME  SIZE  MODEL OR STYLE

FRAME NUMBER  □ PLASTIC □ METAL □ NEW □ COMBINATION □ PATIENT'S

MATERIALS SUPPLIED CHARGES NVA USE

□ SINGLE VISION □ BIFOCAL □ TRIFOCAL □ APHAKIC □ CONTACTS: □ HARD □ SOFT □ TINT #________ COLOR______ □ OTHER ______________

FRAME

TOTAL CHARGE

I HAVE A PRESCRIPTION FOR:! □ SINGLE VISION □ BIFOCAL □ TRIFOCAL □ APHAKIC □ CONTACTS: □ HARD □ SOFT □ TINT #________ COLOR______ □ OTHER ______________

FRAME

TOTAL CHARGE