

MOUNTAIN STATES ADMINISTRATIVE SERVICES

(800) 866-4731 or (520) 722-0811

VISION BENEFITS CLAIM FORM

PLEASE BE AS COMPLETE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM. ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS

PART A. -- TO BE COMPLETED BY EMPLOYEE

PATIENT'S NAME (Last, First, Middle)			2. GROUP #			3. I D CARD NUMBER		
4. PATIENT'S DATE OF BIRTH		5. PATIENT'S SEX <input type="checkbox"/> M <input type="checkbox"/> F		6. RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		7. EMPLOYEE'S NAME (Last, First, Middle)		
8. EMPLOYEE ADDRESS (No., Street, City, State and Zip Code)						9. HOME NUMBER		WORK NUMBER
10. NAME OF EMPLOYER				11. EMPLOYEE'S STATUS <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried			12. EMPLOYEE'S DATE OF BIRTH	
13. PATIENT IS COVERED FOR VISION CARE BY ANOTHER PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, PLEASE COMPLETE BOXES 14 THROUGH 18			14. NAME AND ADDRESS OF OTHER CARRIER		
15. POLICYHOLDER'S NAME			16. RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		17. POLICYHOLDER'S DATE OF BIRTH		18. POLICYHOLDER'S EMPLOYER	
19. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO MOUNTAIN STATES ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.								
PAYMENT FOR ANY BENEFITS SHOULD BE MADE TO:			<input type="checkbox"/> SUBSCRIBER		<input type="checkbox"/> DOCTOR		<input type="checkbox"/> DISPENSER	
SIGNATURE OF EMPLOYEE _____						(DATE SIGNED) _____		

PART B. -- TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME (Last, First, Middle)			2. TITLE <input type="checkbox"/> D.O. <input type="checkbox"/> M.D. <input type="checkbox"/> O.D.			3. Assignment cannot be made without tax I.D. number DOCTOR'S TAX I.D. _____				
4. DOCTOR'S ADDRESS (No., Street, City, State and Zip Code)			5. PHONE ()							
6. EXAMINATION DATE		PLEASE ENTER EXAMINATION CHARGE IN FEE COLUMN BELOW (BLOCK 15)		7. DIAGNOSIS OR NATURE OF OFFICE VISIT			8. HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
9. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTION EYEGLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO		10. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. WERE EYEGLASSES PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO			WERE CONTACTS PRESCRIBED: <input type="checkbox"/> YES <input type="checkbox"/> NO			
12. DOCTOR'S PRESCRIPTION				13. DID YOU PERFORM REFRACTION: <input type="checkbox"/> YES <input type="checkbox"/> NO						
	Sphere	Cylinder	Axis	Prism	14. I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS I INDICATED HEREON.					
R										
L										
READING ADD					DOCTOR'S SIGNATURE				15. EXAMINATION CHARGE	AMOUNT

PART C. -- TO BE COMPLETED BY DOCTOR/DISPENSER

CHECK APPROPRIATE BOX

FRAME	SIZE & MODEL				MFG.	ZYL	METAL	RIMLESS	COMBO	FRAME CHARGE				
LENSES	# OF LENSES	GLASS	PLASTIC	SV	BIF	TRI	PAL	SAFETY	OTHER	LENS CHARGE				
LENS OPTIONS	OS	TINT	GRAD	DBL GRAD	COAT	UV 400	FACET	PHOTO CHROMIC	OTHER	OPTIONS CHARGE				
CONTACT LENSES	# OF LENSES	HCL	SCL	HGP	DISPOSABLE	SPH	BIF	TORIC	EW	TINT	REPLACEMENT	OTHER	CONTACT LENSES	
DATE ORDERED	DATE DISPENSED				OTHER SERVICES				OTHER SERVICES					
DISPENSING OFFICE				PHONE ()				SUBTOTAL						
ADDRESS		STREET		CITY		STATE		ZIP		SALES TAX (If Applicable)				
I hereby certify that I have performed the services as indicated hereon.				Assignment cannot be made without tax I.D. number				TOTAL CHARGES						
				Dispenser's Tax I.D. number _____				AMOUNT PAID BY PATIENT						
DISPENSER'S SIGNATURE				DATE				FOR MOUNTAIN STATES USE ONLY						
								CC:						

PLEASE SUBMIT THIS CLAIM TO Mountain States Administrative Services, 7202 E Rosewood, Ste 200, Tucson, AZ 85710

Fax To: (520) 722-7127