

CLAIM INSTRUCTIONS

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

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187
CLIFTON, NEW JERSEY 07015

If you have any questions, please contact Vibra Vision at (877) 855-6263

Vibra Health Plan is a PPO with a Medicare contract. Enrollment in Vibra Health Plan depends on contract renewal.

Vibra Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-388-8268 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-388-8268 (TTY: 711)。



**CLAIM FOR VISION CARE EXPENSE
 FOR NON-PARTICIPATING PROVIDERS**

TO BE COMPLETED BY MEMBER <i>(Print)</i>					
MEMBER INFORMATION			PATIENT INFORMATION		
LAST NAME	FIRST NAME		MEMBER ID (SSN OR ID#)		
STREET ADDRESS			PATIENT LAST NAME	PATIENT FIRST NAME	
CITY	STATE	ZIP CODE	DATE OF BIRTH / /	GENDER	STATUS
				MALE <input type="checkbox"/>	SPOUSE <input type="checkbox"/>
				FEMALE <input type="checkbox"/>	CHILD <input type="checkbox"/>
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, AND POLICY HOLDER.					
MEMBER'S SIGNATURE _____			DATE _____		
IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? <input type="checkbox"/> YES <input type="checkbox"/> NO 2) SAFETY GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO 3) CATARACT SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE SPACE PROVIDED.					

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST <i>(Print)</i>					
EXAMINER NAME	<input type="checkbox"/> MD <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
CITY	STATE	ZIP CODE	DOES PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON.			DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CHANGES:		SERVICE CHARGE
SIGNATURE _____			DATE _____		\$ _____
			AXIS _____		SPHERE/CYLINDER _____
I HAVE PRESCRIBED: <input type="checkbox"/> SINGLE VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> APHAKIC CONTACTS: <input type="checkbox"/> HARD <input type="checkbox"/> SOFT <input type="checkbox"/> COSMETIC <input type="checkbox"/> MEDICALLY REQUIRED					

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