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 Health Plan 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 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 844.388.8268 (TTY: 711)。

vibra HEALTH PLAN

Vibra Health Plan Vision

NATIONAL VISION ADMINISTRATORS
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
877.855.6263

CLAIM FOR VISION CARE EXPENSE
FOR NON-PARTICIPATING PROVIDERS

TO BE COMPLETED BY MEMBER (*Print*)

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 ☐ FEMALE	☐ SPOUSE ☐ CHILD

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)? ☐ 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. 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*)

DISPENSER NAME	TAX ID#	PATIENT NAME	DATE OF SERVICE
STREET ADDRESS			
CITY	STATE ZIP CODE		

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.

SIGNATURE_____ DATE_____

Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD
RIGHT					
LEFT					

LENSES	U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE			
	TRADE NAME	WIDTH	☐ PAIR ☐ ONE ☐ GLASS ☐ PLASTIC	
FRAMES	MANUFACTURER NAME	SIZE	MODEL OR STYLE	
	FRAME NUMBER	☐ PLASTIC ☐ METAL ☐ COMBINATION	☐ NEW ☐ PATIENT'S	

MATERIALS SUPPLIED	CHARGES	NVA USE
☐ SINGLE VISION		
☐ BIFOCAL		
☐ TRIFOCAL		
☐ APHAKIC		
☐ CONTACTS ☐ HARD ☐ SOFT		
☐ TINT #_____ COLOR_____		
☐ OTHER _____		
FRAME		
TOTAL CHARGE		