RETURN COMPLETED FORM TO:
3925 Fountains Blvd NE, Suite 104
Cedar Rapids, IA 52411
(319) 365-2810

IA LAB

CLAIM FORM
VISION CARE BENEFITS

EMPLOYEE INFORMATION - REQUIRED for all claims

Name of Employee _____ Date of Birth _____
(Last) (First) (Middle)

Employee's Marital Status: Single ____ Married ____ Widowed ____ Divorced ____ Separated ____

Social Security No. _____ Occupation _____ Active ☐ Retired ☐

Street Address _____

City, State _____ Zip _____ Phone number ( ) _____

DEPENDENT INFORMATION - If Claim is For Your Dependent

Name of Dependent _____

Relationship to Employee _____ Date of Birth _____

Dependent's Marital Status: Single ____ Married ____ Widowed ____ Divorced ____ Separated ____

Is Dependent Employed?
☐ YES ☐ NO
If YES, Name _____
Address _____
City, State _____ Zip _____

Is Dependent Attending School?
☐ YES ☐ NO
If YES, Name _____
Address _____
City, State _____ Zip _____

OTHER INSURANCE INFORMATION

Do you **or** your Dependents have ANY other health insurance? ☐ YES ☐ NO IF YES,

A) Name of the person insured _____ Relationship to Employee _____

B) Insured person's employer _____

C) Employer's street address _____

City, State _____ Zip _____

D) Policy number _____ Certificate number _____ Social Security number _____ Phone number ( ) _____

NOTE: Attach copy of payment worksheet or denial from other insurance.

ACCIDENT INFORMATION

If this treatment was required due to accidental injury, please complete Accidental Information section on other side of this form.

AUTHORIZATION

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative, of any facts concerning the treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee's Signature _____ Date _____

Patient's Signature _____ Date _____

ASSIGNMENT

I hereby authorize payment of Vision Care Benefits directly to the provider(s) of services and materials described on the reverse side of this form.

Employee's Signature _____

Date _____

YOU MUST SIGN FORM ON THE REVERSE SIDE

TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST

PATIENT'S NAME _____ AGE _____

1. Indicate the nature of eye examination: _____Initial Exam _____Continuing Care

   _____Complete examination, including eye refraction. Date of Exam _____ Fee $_____

   _____Complete examination, excluding eye refraction. Date of Exam _____ Fee $_____

2. Has patient previously had glasses? _____YES (Give Date _____) _____NO

3. Does patient require a prescription change at this time? _____YES _____NO

4. Were tinted lenses prescribed? _____YES _____NO

5. Are these lenses to be used primarily as sunglasses? _____YES _____NO

6. Materials prescribed or provided:

			ONE	TWO	EACH	TOTAL
FRAMES	$ _____	LENSES-SINGLE VISION	☐	☐	$ _____	$ _____
SUB-NORMAL VISION AIDS	$ _____	LENSES-BIFOCAL	☐	☐	$ _____	$ _____
		LENSES-TRIFOCAL	☐	☐	$ _____	$ _____
		LENSES-LENTICULAR	☐	☐	$ _____	$ _____
		LENSES-CONTACT	☐	☐	$ _____	$ _____
				TOTAL	$ _____	$ _____

7. Are frames or lenses being replaced as a result of breakage, or loss? (Circle One) Frames: YES NO Lenses: YES NO

8. If contact lenses are being prescribed, please answer the following:

   a) Are these lenses for cosmetic purposes? _____YES _____NO

   b) Is this the first pair following cataract surgery? _____YES _____NO (If YES provide the date of surgery _____)

   c) Would the visual acuity be corrected to 20/70 in better eye by use of conventional lenses? _____YES _____NO

   d) Will the use of contact lenses correct the visual acuity to 20/70 or better? _____YES _____NO

DOCTOR'S SIGNATURE | DEGREE | DATE

PRINT OR TYPE DOCTOR'S NAME | TAX I.D. NO. | TELEPHONE NO.

STREET ADDRESS | CITY | STATE | ZIP

TO BE COMPLETED BY OPTICIAN OR LAB

1. Materials prescribed or provided:

			ONE	TWO	EACH	TOTAL
FRAMES	$ _____	LENSES-SINGLE VISION	☐	☐	$ _____	$ _____
SUB-NORMAL VISION AIDS	$ _____	LENSES-BIFOCAL	☐	☐	$ _____	$ _____
		LENSES-TRIFOCAL	☐	☐	$ _____	$ _____
		LENSES-LENTICULAR	☐	☐	$ _____	$ _____
		LENSES-CONTACT	☐	☐	$ _____	$ _____
				TOTAL	$ _____	$ _____

2. Date service began _____ 3. Date service completed _____

PROVIDER'S SIGNATURE | DATE

PRINT OR TYPE PROVIDER'S NAME | TAX I.D. NO. | TELEPHONE NO.

STREET ADDRESS | CITY | STATE | ZIP