



An Independent Licensee of the Blue Cross and Blue Shield Association.
450 Riverchase Parkway East • Birmingham, Alabama 35244-2858

VISION CLAIM
 HEARING CLAIM

TYPE OR PRINT

PATIENT & INSURED (SUBSCRIBER) INFORMATION													
1. Patient's Name <i>(First name, middle initial, last name)</i>			2. Patient's Date Of Birth MM DD YYYY 			3. Insured's Name <i>(First name, middle initial, last name)</i>							
4. Patient's Address <i>(Street, city, state, ZIP code)</i>			5. Patient's Sex <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			6. Insured's I.D. Number <i>(Include any letters)</i>							
9. Other Health Insurance Coverage <small><i>(Name of Policyholder, Plan Name and Address, and Policy or Medical Assistance Number. Attach a copy of your carrier benefit payment notice showing charges submitted and payments made.)</i></small>			7. Patient's Relationship To Insured Self Spouse Child Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			8. Insured's Group Number <i>(Or Group Name)</i>							
			10. Was Condition Related To A. Patient's Employment <input type="checkbox"/> YES <input type="checkbox"/> NO B. An Auto Accident <input type="checkbox"/> YES <input type="checkbox"/> NO C. An Accident <input type="checkbox"/> YES <input type="checkbox"/> NO			11. Insured's Address <i>(Street, city, state, ZIP code)</i>							
12. A. DATE OF SERVICE		B. PLACE OF SERVICE	C. PROCEDURE CODE	D. TOTAL CHARGES	E. NO. OF SERVICES	13. Diagnosis							
FROM TO													
MM DD YYYY MM DD YYYY 						16. Referring Doctor or Provider							
										17. Referring Physician UPIN Number			
										18. Signature of Physician or Supplier			
CLAIM TOTAL:													
14. D I S T A N C E	R I G H T	SPHERE		CYLINDER		AXIS		PRISM		19. Make Payment To: <input type="checkbox"/> PROVIDER <input type="checkbox"/> PATIENT			
	L E F T												
The lens prescription must be included for reimbursement of lens purchase.													
15. TYPE LENSE <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL <input type="checkbox"/> PLANO <input type="checkbox"/> GLASS LENS <input type="checkbox"/> PLASTIC LENS <input type="checkbox"/> CONTACT LENS						Telephone Number [] -							
						21. Provider Number			22. Tax ID Number				