Benefit Administrators, Inc.
Claims Divison
PO Box 211757
Eagan, MN 55121
1-800-298-7269

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Plan No./No. Plan ____ Claim No./No. Reclamo ____

VISION CARE—CUIDADO DE LA VISTA

Part I: To be completed by the employee / Para ser completado por el empleado

1. Patient Name/Nombre del Paciente *(first, middle initial, last / nombre, inicial, appelido)*	2. Patient Birthdate/Fecha de Nacimiento del Paciente *(month, day, year / mes, día, año)*	3. Relationship to Member/Relación con el miembro	4. Sex / Sexo Male/Masculino Female/Femenino
5. Member Name/Nombre del Miembro *(first, middle initial, last / nombre, inicial, appelido)*	6. Member ID Number/Número de Miembro	7. Member's Birthdate/Fecha de nacimiento del miembro *(month, day, year / mes, día, año)*	

8. Member Mailing Address/Dirección Postal del Miembro *(Street address, City, State, ZIP / Dirección, Ciudad, Estado, Código Postal)*

9. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER. Esta sección debe ser completada con cada reclamación solamente si el reclamo es para un hijo dependiente de 19 o más.

Is the patient a full-time student? / ¿Es el paciente un estudiante a tiempo completo?

Yes / Si No

If yes, name and address of school / En caso afirmativo, el nombre y la dirección de la escuela

10. Policy Number/Número de Póliza	Division Number/Número de División	Certificate Number/Número de Certificado

11. I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all costs of treatment. I certify these statements to be true and complete to the best of my knowledge. *He revisado el siguiente plan de tratamiento, y autorizo la liberación de cualquier informationrelating a este reclamo. Entiendo que soy responsable de todos los costos de tratamiento. Certifico estas declaraciones es verdadera y completa a lo mejor de mi conocimiento.*

Employee's Signature
Firma del Empleado

Date

12. I hereby authorize payment directly to the below-named provider of group insurance benefits otherwise payable to me.
Por la presente autorizo el pago directamente al proveedor abajo mencionado grupo de seguro que correspondería pagar a mí.

Patient's Signature
Firma del Paciente

Date

Part 2: To be completed by the vision provider / Para ser completado por el proveedor de la vista

1. Eye Care Provider name and mailling address

Specialty	Phone number
Email	Fax number
Federal tax ID number	National Provider Identifier (NPI)

4. Provider license number

For "yes" answers to questions 5 through 7, provide brief explanation under *Remarks.*

5. Is treatment result of occupational illness or injury? Yes / Si No
6. Is treatment result of an auto accident? Yes / Si No
7. Other accident? Yes / Si No
8. This is a: *(please check one)* Statement of services Pretreatment Estimate
9. Is this for LASIK/PRK? Yes / Si No

10. Date of Service	11. Exam	12. Materials

11. **Examination and Treatment Record** Please include date of service, description of services, procedure codes and fees.

Service	CPT Code	Fee
LASIK / PRK Left eye		$
Right eye		$
Exam		$
Lens fitting		$
Refraction		$
Other		$
Frames		$

Lenses	CPT Code	Fee
Single		$
Bifocal		$
Trifocal		$
Progressive		$
Lenticular		$
Contacts		$
Other		$

Options	CPT Code	Fee
Anti-reflective		$
Scratch resistl		$
Tint High-		$
index Edge		$
polish Others		$
Discounts		$

12. Remarks

13. Total
$

14. **Certification:** I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.

Provider's Signature

Date

15. Address where treatment was performed

Receipt from the provider of service must be attached to your claim form for member reimbursement.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Any person who **knowingly presents a false or fraudulent claim** for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Important Notice

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.
- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ***For residents of Maine, Tennessee and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- ***For residents of Texas:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.