# **vision** Group Claim Form

**Ameritas Life Insurance Corp. of New York**

Ameritas

Group Claims Adjusters / P.O. Box 82595 Lincoln, NE 68501-2595 / Toll Free 800-659-5556 / Fax 402-467-7336 / Web ameritas.com

## Part 1: To be completed by Employee

| 1. Patient's full name (first, middle initial, last) | 2. Patient birthdate (MM/DD/YY) / / | 3. Relationship to employee ☐ Self ☐ Spouse ☐ Child ☐ Other | 4. Sex ☐ M ☐ F |
|---|---|---|---|
| 5. Employee's full name (first, middle initial, last) | 6. Employee's identification number | Employee's birthdate (MM/DD/YY) / / | |

| 7. Employee's mailing address (street address or P.O. Box, City, State, ZIP)<br>Email address: | 8. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER<br>Is patient a full-time student? ☐ Yes ☐ No<br>If Yes, name and address of school: |
|---|---|

| 9. Employer (company) name and address | 10. Group number | Division number | Certificate number |
|---|---|---|---|

**Questions 11 and 12 must be completed with each claim submission.**

| 11. Is patient covered by another vision plan? ☐ Yes ☐ No | Name and address of other carrier | Policy number | Name and address of other employer: |
|---|---|---|---|

| 12. Other employee/subscriber name | Employee/subscriber identification number | Date of birth (MM/DD/YY) / / | Relationship to patient |
|---|---|---|---|

| 13. **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 cost of treatment. I certify these statements to be true and complete to the best of my knowledge.**<br>X _____ _____<br>Signature (patient, or parent if minor) Date | Check one box only:<br>14A. ☐ **Please send payment to me OR**<br>14B. ☐ **Please pay provider below**<br>X _____ _____<br>Signature (insured person) Date |
|---|---|

## Part 2: To be completed by Attending Vision Provider.

**IMPORTANT: Please attach an itemized receipt including provider's name and address, specific procedures and materials purchased. If this is attached, you will not need to complete Part 2.**

| 15. Vision care provider name and address | **For Yes answers to questions 17-19, enter a brief description and dates.**<br>17. Is treatment result of occupational illness or injury? ☐ Yes ☐ No<br>18. Is treatment result of auto accident? ☐ Yes ☐ No |
|---|---|

| Specialty | Phone number | 19. Other accident? ☐ Yes ☐ No |
|---|---|---|
| Email | Fax number | 20. This is a (please check one): ☐ Statement of actual services ☐ Pretreatment estimate |
| 16. Federal Tax ID Number ☐ SSN ☐ TIN | NPI (National Provider Identifier) | 21. Is this for LASIK/PRK? ☐ Yes ☐ No |

| License # | 22. Date of Service | Exam | Materials |
|---|---|---|---|

23. **Examination and Treatment Record** Please include date of service, description of services, procedure code and fee.

| Service | CPT Code | Fee | Lenses | CPT Code | Fee | Options | CPT Code | Fee |
|---|---|---|---|---|---|---|---|---|
| LASIK/ PRK left eye | | $ | Single | | $ | Anti-reflective | | $ |
| right eye | | $ | Bifocal | | $ | Scratch resist | | $ |
| Exam | | $ | Trifocal | | $ | Tint | | $ |
| Lens fitting | | $ | Progressive | | $ | Hi-index | | $ |
| Refraction | | $ | Lenticular | | $ | Edge polish | | $ |
| Other | | $ | Contacts | | $ | Other | | $ |
| Frames | | $ | Other | | $ | Discounts | | |

| 24. Remarks | 25. Total $ |
|---|---|

| 26. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees subm itted are the fees I have charged and intend to collect for those purposes.<br>X _____ _____<br>Signature (Provider) Date | 27. Address where treatment was performed |
|---|---|

# tips to speed claims processing

## Part 1 – Employee

Missing or incomplete information will slow down claims processing. To avoid this, please be sure to include:

**#2 – Patient birthdate**
Helps identify an insured and determine dependent eligibility.

**#6 – Employee's identification number**
This is the most important identifier for the plan member.

**#8 – Student status**
Because this information often changes, it is required on every claim for dependents age 19 years and older.

**#11 and #12 – Coordination of benefits**
The No box under #11 should be checked if no other vision coverage exists. If there is other vision coverage, the additional information requested is necessary for coordination of benefits.

## Part 2 – Vision Provider

To help expedite the claims process, please be sure to include:

**#16 – National Provider Identifier**
There are two types of NPI. Type 1 is for individual providers who operate independently. Type 2 is for health care providers such as group practices or corporations. Type 2 organization providers may want their individual provider employees to have Type 1 NPIs to distinguish them individually.

**#21 and #23 – LASIK/PRK**
If LASIK or PRK, please make sure your vision provider marks the Yes box under #21, and includes description of services, procedure code, which eye (left, right or both), and the fee for each eye in the Examination and Treatment Record.

**#20 – Statement of actual services, or Pretreatment estimate**
Appropriate box should be marked to ensure correct handling.

**NOTE:** If there are two different providers (one for the exam, another for eyewear), we request that each provider submit a separate claim form.

## Pretreatment Estimate of Benefits

We recommend a pretreatment estimate of benefits when a plan member considers the services to be expensive. A pretreatment estimate lets both the member and vision provider know in advance how much insurance will pay. If vision coverage terminates for any reason during treatment, only procedures performed before coverage ended will be eligible for payment.

For full information regarding coverage, plan members may refer to their insurance plan booklet.

## Website

Visit our website for benefit information, electronic forms, a list of vision providers if your plan includes a network, and more. Please note, the free software Adobe Reader® (available through the internet) is needed to view and print the electronic forms.