# eye care
## group claim form

**Group Claim Office / P.O. Box 82520 / Lincoln, NE 68501-2520**
Toll Free 800.255.4931 / Fax 402.467.7336 / Web ameritasgroup.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)
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
Is patient a full-time student? ☐ Yes ☐ No
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 eye care 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.**

X
Signature (patient, or parent if minor) Date

14. **I hereby authorize payment directly to the below named provider of group insurance benefits otherwise payable to me.**

X
Signature (insured person) Date

**It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and/or civil penalties can result from such acts.**

**PART 2 – TO BE COMPLETED BY ATTENDING EYE CARE PROVIDER.**

15. Eye care provider name and mailing address
Specialty
Phone number
Email
Fax number
16. Federal tax ID number ☐ SSN ☐ TIN
NPI (National Provider Identifier)
License #

**For Yes answers to questions 17-19, enter a brief description and date.**

17. Is treatment result of occupational illness or injury? ☐ Yes ☐ No
18. Is treatment result of auto accident? ☐ Yes ☐ No
19. Other accident? ☐ Yes ☐ No
20. This is a (please check one): ☐ Statement of actual services ☐ Pretreatment estimate
21. Is this for LASIK/PRK? ☐ Yes ☐ No

**22. EXAMINATION AND TREATMENT RECORD** Please include date of service, description of services, procedure code and fee.

| Date service performed (MM/DD/YY) | Description of services | CPT/HCPCS procedure code | Diagnosis code | LASIK PRK | Left eye | Right eye | Fee |
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23. Remarks

24. Total
$ **$0.00**

25. 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.

X
Signature (Provider) Date

26. Address where treatment was performed

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