Vision Claim Form

Complete and send to:
Prodegi Corporate Benefit Services
P.O. Box 98 Worland, WY 82401
Fax (307) 346-6227

For ALL claims, this area must be filled in completely.

Employee Information			
Employee's Name (last, first, middle initial)			Employee ID Number
Address			Employee's Date of Birth
City	State	Zip Code	☐ Single ☐ Married ☐ Widowed ☐ Divorced

If the patient is a dependent, please complete ALL of the following. If the patient is the employee, go directly to the area below the shaded box.

Patient Information			
Patient's Name (if other than employee)			Patient's ID Number
Patient's Date of Birth (Month, Day, Year)		Relationship to Employee ☐ Spouse ☐ Child	If child, is (s)he married? ☐ Yes ☐ No
Is patient covered by another Employer Group Plan or Retirement Group Plan? ☐ Yes ☐ No (If yes, please complete the two items below)			
Name of Employer	Group Number	Name and address of Insurance Company or Organization	

Release

Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud, submits an application for coverages, or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Criminal and/or Civil penalties can result from such acts.

I hereby authorize payment of these benefits be send directly to:
☐ Provider of Service ☐ Employee **(attach itemized bill or receipt)**

Patient's Signature (parent or guardian if claim is on a minor)	Date

The below sections are to be completed by the Provider.

Exam		
Indicate the nature of disease, injury or vision disorder	Date of examination	Name of provider performing services
Refraction? Yes ☐ ☐ No Contact Lenses? Yes ☐ ☐ No Tonometry? Yes ☐ ☐ No Cataract Surgery? Yes ☐ ☐ No		Address
Examination Charge: $		City
Amount paid by employee: $		State / Zip Code
Signature of provider	Degree/Title / Date	Provider's Social Security or Tax ID Number (required by law):

Lenses						**Frames**			
Date ordered:		Date dispensed:		☐ Pair ☐ 1/2 Pair		Date ordered	Date dispensed	Parts ☐ Complete ☐ Partial	
	Sphere	Cylinder	Axis	Prism	Add			**Frame Charge**	**$**
OD						Name of provider performing services (please print)			
OS									
Type Lens:				**Charge**					
☐ Single vision ☐ Bifocal ☐ Trifocal ☐ Lenticular						Address	City, State, Zip		
☐ Contact Lenses									
☐ Oversized Lenses									
☐ Sunglasses						Provider's Social Security Number or Tax ID Number			
☐ Tint #									
☐ Photosensitive – i.e. Brown, Gray, etc.						Signature of provider	Degree/Title	Date	
☐ Other									
Lens Manufacturer:						**Total Charge:**	**$**	**Amount paid by employee:**	**$**
Lens Charge				**$**					

IMPORTANT: CLAIMS CANNOT BE PAID UNTIL THE CLAIM FORM IS PROPERLY COMPLETED AND RECEIVED. Do not send this form through your employer. ATTACH PROVIDER BILLING. If you require assistance in presenting this claim, call your Service Delivery Team at the number listed on your member ID Card.