



VISION CLAIM FORM
 Eligibility Verification 1-888-236-1100
 MAIL CLAIM FORM TO: ADN
 PO BOX 610
 SOUTHFIELD, MI 48037

EMPLOYER NAME: _____

EMPLOYEE AND PATIENT PORTION

EMPLOYEE'S CONTRACT NUMBER/SSN	EMPLOYEE FIRST & LAST NAME	DATE OF BIRTH
--------------------------------	----------------------------	---------------

EMPLOYEE'S ADDRESS	PATIENT NAME
	PATIENT'S RELATIONSHIP TO EMPLOYEE SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>

OTHER INSURANCE COVERAGE YES NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER
 IS PATIENT COVERED BY ANOTHER VISION PLAN?

SOCIAL SECURITY NUMBER OF OTHER INSURED	NAME OF EMPLOYER
---	------------------

OTHER INSURED'S NAME	DATE OF BIRTH
----------------------	---------------

IS THIS CONDITION CAUSED BY EMPLOYMENT? EXPLAIN	DOES CLAIM INVOLVE INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/> WAS PATIENT INJURED AT WORK? YES <input type="checkbox"/> NO <input type="checkbox"/> DATE AND TIME OF INJURY _____
---	---

I AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED DURING MY EXAM OR TREATMENT.	I AUTHORIZE PAYMENT OF BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER OF SERVICES DESCRIBED BELOW. <u>DO NOT SIGN IF YOU HAVE PAID UP FRONT FOR SERVICES</u>
SIGNED (EMPLOYEE OR PATIENT) DATE	SIGNED (EMPLOYEE OR PATIENT) DATE

TO BE COMPLETED BY SERVICE PROVIDER OR ATTACH A DETAILED RECEIPT OR CLAIM

DATE(S) OF SERVICE	PROCEDURE CODE	DESCRIPTION	DIAGNOSIS	CHARGE

BILLING ENTITY AND ADDRESS	TAX ID NUMBER -
	PHYSICIAN'S LICENSE NUMBER -
PHONE NUMBER -	SIGNATURE OF TREATING PHYSICIAN DATE