MBA

THE OPEN SOLUTION™

Vision Care Claim Form

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO

MBA Benefit Administators
PO Box 57340, Murray, UT 84157-0340

PART 1 MUST BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	NAME OF EMPLOYER	
HOME ADDRESS	EMPLOYEE BIRTH DATE MO/DAY/YEAR	OCCUPATION	GROUP NO
CITY & STATE / ZIP CODE	PHONE NO.	IS PATIENT FULLTIME STUDENT Y N	NAME & ADDRESS OF SCHOOL
PATIENT (IF OTHER THAN EMPLOYEE) NAME	SEX / PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT BIRTH DATE MO/DAY/YR	IS PATIENT MARRIED Y N
NAME OF SPOUSE	NAME AND ADDRESS OF SPOUSE'S EMPLOYER		

ARE YOU THE PATIENT OR SPOUSE. COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THE EXPENSES OF THIS CLAIM? YES___ NO ___ IF YES, GIVE NAME, ADDRESS& POLICY NUMBER OF PLAN PROVIDING BENEFITS.
NAME AND ADDRESS POLICY NO.

IF PAYMENT IS TO BE MADE TO PROVIDER. SIGN BELOW

ASSIGNMENT:
PLEASE PAY BENEFITS UNDER THIS CLAIM DIRECTLY TO:

☐ HOSPITALS ☐ DOCTORS ☐ EMPLOYEE

A AUTHORIZATION TO PAY BENEFITS TO PROVIDERS:
I hereby authorize payment of benefits directly to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Covered Person Date

PATIENT OR PARENT MUST SIGN BELOW

B AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

X _____
Patient or Parent of Minor Date

PART 2 TO BE COMPLETED BY DOCTOR OR PROVIDER

PATIENT'S NAME	BIRTH DATE	DOES PATIENT HAVE OTHER COVERAGE? Y N	IF YES, PLEASE IDENTIFY
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? Y N	GIVE DETAILS		

DATE SERVICE BEGAN _____

DATE SERVICE COMPLETED _____

INCLUDING TONOMETRY Y N
INCLUDING REFRACTION Y N

IS THIS A REPLACEMENT? Y N
IF "YES", PLEASE GIVE REASON FOR REPLACEMENT _____

IF CONTACT LENSES. WOULD THE VISUAL ACUITY BE CORRECTED TO 20/70 IN THE BETTER EYE BY USE OF CONVENTIONAL LENSES?

	ONE	TWO
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

$ _____ Examination
$ _____ Frames
$ _____ Lenses - Single Vision
$ _____ Lenses - Bifocal
$ _____ Lenses - Trifocal
$ _____ Lenses - Contact
$ _____ Lenses - Lenticular
Total Charges $ _____

TYPE OR PRINT IDENTIFICATION NUMBER

PHYSICIAN'S NAME

ADDRESS

CITY/ZIP

DEGREE

PHONE _____ DATE

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED.
I ALSO CERTIFY ALL INFORMATION IS CORRECT.

DOCTOR'S OR PROVIDER'S SIGNATURE X _____

CRITIQUE A Healthcare Advocate HEALTHSTEPS MBA BENEFIT ADMINISTRATORS