



# MedBen VisionPlus Claim Form

Patient's Name	Date of Birth	Exam	Lens	Frame	ID#	Claim #	Issue Date	Exp. Date

\$/\\$ = Single Vision / Multifocal = Maximum charges for non-covered extras C=Covered

AR Coat	Mid Index (Plastic) <sup>1</sup>	Polycarbonate <sup>3</sup>	Sun/Solid/Color
Blended Lens	Oversize Lenses (61)	Progressive <sup>1</sup>	UV Coating
Gradient Tint	Photochromic-Glass <sup>2</sup>	Rimless	H. Index (Plastic)
Ground-in Prism	Photochromic-Plastic <sup>3</sup>	Roll/Edge Polish	Aspheric
H. Index (Glass)	Pink Tints (#1 & 2)	Scratch Coat	Polarized

<sup>1</sup>includes scratch coat    <sup>2</sup>includes UV coating    <sup>3</sup>includes scratch & UV coatings

Special Instructions/Comments to Lab/Doctor

### EXAM/FITTING FEES - Please list separately

Exam Date	Procedure Code	Fully Describe Procedure	Diagnosis Code	Retail Charges

Patient's Prescription	Sphere	Cylinder	Axis	Prism	Add	Seg. Height	Seg. Width	Eye Size	P.D.
OD									
OS									

### LENS - Please indicate your retail charges

#### Materials Date of Service:

**Lens Type (pair):**  Single Vision \$ \_\_\_\_\_  Bifocal \$ \_\_\_\_\_  Trifocal \$ \_\_\_\_\_  
 Blended \$ \_\_\_\_\_  Progressive \$ \_\_\_\_\_  Lenticular \$ \_\_\_\_\_

**Lens Material:**  Glass  Plastic  Polycarbonate (extra cost) \_\_\_\_\_

**Lens Extra:**  AR Coat \$ \_\_\_\_\_  Gradient Tint \$ \_\_\_\_\_  Photochromic \$ \_\_\_\_\_  Scratch Coat \$ \_\_\_\_\_  
 Aspheric \$ \_\_\_\_\_  Mid Index \$ \_\_\_\_\_  Rimless/Grooved \$ \_\_\_\_\_  Sun/Solid/Color \$ \_\_\_\_\_  
 Diamonex \$ \_\_\_\_\_  Oversize Lens \$ \_\_\_\_\_  Roll/Edge Polish \$ \_\_\_\_\_  UV Lenses \$ \_\_\_\_\_  
 High Index \$ \_\_\_\_\_  Polarized \$ \_\_\_\_\_  Other (please specify) \_\_\_\_\_

**Contact Lenses:**  Cosmetic (retail cost before discount) \$ \_\_\_\_\_ Type \_\_\_\_\_  
 Necessary Contacts \$ \_\_\_\_\_ (see Participating Provider Manual for instructions)

### FRAME

New     Patient's Own     Lab Supply    Retail \$ \_\_\_\_\_    Wholesale \$ \_\_\_\_\_  
Frame Name: \_\_\_\_\_ Manufacturer: \_\_\_\_\_ Temple: \_\_\_\_\_ Color: \_\_\_\_\_ Style: \_\_\_\_\_

### SPECIAL INSTRUCTIONS FROM DOCTOR

### EXPLANATION OF PATIENT CHARGES

**Eyeglasses**  
Exam Deductible \$ \_\_\_\_\_  
Materials Deductible \_\_\_\_\_  
Frame Allowance \$ \_\_\_\_\_ Excess \_\_\_\_\_  
Extras: \_\_\_\_\_  
Sales Tax \_\_\_\_\_  
**Total Patient Charges (with coverage)** \_\_\_\_\_

**Contact Lenses - Replaces \_\_\_\_\_ services**  
Patient Charge for Exam \$ \_\_\_\_\_  
Patient Charge for Fitting Fee \$ \_\_\_\_\_  
Contact Materials Charge, less \_\_\_\_\_% - \_\_\_\_\_  
Sales Tax \_\_\_\_\_  
Contact Lens Allowance - \_\_\_\_\_  
**Total Patient Charges** \$ \_\_\_\_\_

**TOTAL PATIENT CHARGES WITHOUT COVERAGE WOULD BE \$ \_\_\_\_\_**

I certify that the patient shown above is eligible for the coverages shown and agree to pay the deductible to the provider plus any items which are not covered by the group's VisionPlus plan.  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, files a claim containing a false or defective statement is guilty of insurance fraud.

Dr's. Name, Address, Phone & Taxpayer ID#	Lab/Dispenser Name, Address, Phone & Taxpayer ID#	Arrival Date _____
		Mail Date _____
	Dr's. Signature	Invoice # _____