

# EMI Health

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## Vision Claim Form

TO BE COMPLETED BY MEMBER		
PATIENT NAME	RELATIONSHIP TO EMPLOYEE	PATIENT BIRTHDATE
EMPLOYEE NAME	EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE PHONE
EMPLOYEE ADDRESS		
EMPLOYER NAME	IS PATIENT COVERED BY ANOTHER VISION PLAN?	OTHER VISION PLAN NAME
OTHER INSURANCE COMPANY NAME AND ADDRESS		
DO YOU WANT PAYMENT TO GO DIRECTLY TO THE PROVIDER?	I CERTIFY THAT THE INFORMATION ON THIS CLAIM IS CORRECT AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.  SIGNED (PATIENT OR PARENT OF MINOR PATIENT):	

TO BE COMPLETED BY DISPENSER					
<b>IN LIEU OF DISPENSER COMPLETING THIS SECTION, A LABORATORY BILL MAY BE ATTACHED.</b>			PROFESSIONAL SERVICES	AMOUNT	
DISPENSER NAME	TAX PAYER IDENTIFICATION NO.		Lens charge		
DISPENSER ADDRESS	PHONE NUMBER		Frame charge		
DISPENSER TITLE <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optician <input type="checkbox"/> Optometrist	MATERIALS SUPPLIED Tint # _____ <input type="checkbox"/> Oversized <input type="checkbox"/> Glass <input type="checkbox"/> Plastic <input type="checkbox"/> Pair <input type="checkbox"/> Half pair <input type="checkbox"/> Other _____		LENS	Materials	
TYPES OF LENSES DISPENSED <input type="checkbox"/> None <input type="checkbox"/> Sunglasses <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular <input type="checkbox"/> Contacts <input type="checkbox"/> Other _____	DATE ORDER _____ DELIVERY _____			Dispenser Fee	
CONTACT LENSES <input type="checkbox"/> Therapeutic <input type="checkbox"/> Non-therapeutic <input type="checkbox"/> Permanent lenses <input type="checkbox"/> Disposable lenses	FRAME MODEL OR CAT NO.	FRAME MFG. NAME	FRAMES	Materials	
I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON				Dispenser Fee	
				Sales tax (if any)	
DISPENSER'S SIGNATURE _____				TOTAL	