Vision Claim Form

Mail: Core Management Resources
P.O. Box 90
Macon, GA 31202
Fax: 478-750-1705

This form can be used for all vision plans.

This form needs to be completed only if the provider is not submitting the claim on your behalf.

Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf.

Please print clearly

PATIENT INFORMATION			MEMBER INFORMATION		
NAME Last	First	MI	MEMBER ID NUMBER or SOCIAL SECURITY NUMBER		
DATE OF BIRTH	SEX ❑ M ❑ F	RELATION TO MEMBER ❑ Self ❑ Spouse ❑ Child	NAME Last	First	MI
DOES THE PATIENT HAVE OTHER VISION INSURANCE COVERAGE? ❑ Yes ❑ No			ADDRESS		
NAME/ADDRESS OF OTHER VISION INSURANCE COMPANY			CITY	STATE	ZIP CODE
			DAYTIME TELEPHONE # ( )	DATE OF BIRTH	
GROUP/POLICY NUMBER					

PROVIDER INFORMATION

PROVIDER NAME		TELEPHONE #
ADDRESS	CITY	STATE ZIP CODE

SERVICES OR SUPPLIES PROVIDED	DATE OF SERVICE (Mo/Day/Year)	CHARGES
❑ Eye Examination		$
❑ Frames		$
❑ Single Vision Lenses		$
❑ Bifocal Lenses		$
❑ Trifocal Lenses		$
❑ Contact Lenses		$
❑ Medically Necessary Contact Lenses		$
PROOF OF PAYMENT		**TOTAL**
Provider will be paid unless receipt of payment is attached with claim form.		$

PAYMENT INSTRUCTIONS (If signed, payment will be made directly to provider)

I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s).

MEMBER'S SIGNATURE **DATE**

X

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Member, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

MEMBER'S SIGNATURE **DATE**

X