

Vision Claim Filing Checklist

Before filing a vision claim the member should ensure that the following is completed for timely processing:

- ✓ Copy of superbill from a provider's office or sales receipt is attached to claim form
- ✓ Ensure that all documentation is legible and provider's tax identification number is present on a claim
- ✓ Ensure that provider signature is present on claim
- ✓ Ensure that the above documentation is attached to a Routine Vision Service Report

An Independent Licensee of the Blue Cross Blue Shield Association

P
A
T
I
E
N
T

I
N
F
O
R
M
A
T
I
O
N

DIAGNOSIS
V 720

PATIENT LAST NAME FIRST

PATIENT STREET ADDRESS

CITY STATE ZIP CODE

HOME PHONE PATIENT'S SEX PATIENT'S DATE OF BIRTH PATIENT'S RELATIONSHIP TO MEMBER
M F SELF SPOUSE CHILD OTHER

ATTENTION!
Please keep all written information within the screened boxes to assure timely processing of this form.

Thank you!

OTHER GROUP HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER, PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER FOR VISION BENEFITS ONLY. IF NONE SO STATE.

POLICY NO.

PAYMENT TO PROVIDER PAYMENT TO SUBSCRIBER

I authorize the release of any medical information necessary to process this claim and also certify that the above information is correct.

I authorize payment of benefits to undersigned provider for services described below.

Authorized Person's Signature Date

Authorized Person's Signature

T
O
B
E

C
O
M
P
L
E
T
E
D

B
Y

P
R
O
V
I
D
E
R

DATE OF SERVICE	✓	PROCEDURE CODE	When "OTHER" is checked, fully describe services or supplies furnished	CHARGES	
		V2020	Frames		
		V2199	Single Vision Lens		
		V2299	Bifocal Lens		
		V2317	Trifocal Lens		
		V2781	Progressive Lens		
		V2599	Contact Lens (List Type)		
			OTHER SERVICES		
		S0620	Routine ophthalmological examination including refraction; new patient		
		S0621	Routine ophthalmological examination including refraction; established patient		
		S0592	Comprehensive contact lens evaluation		

PRINT CLEARLY - BLACK INK ONLY TOTAL CHARGES →

TAX I.D. NO. LICENSE NO. YOUR PATIENT'S ACCOUNT NO.

LAST NAME FIRST

PROVIDER STREET ADDRESS

CITY STATE ZIP CODE

PHONE

I CERTIFY THAT I PERSONALLY RENDERED THE SERVICES DESCRIBED ABOVE TO THIS MEMBER

AUTHORIZED SIGNATURE

PRINT CLEARLY - BLACK INK ONLY