# 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

BlueCross BlueShield of Georgia

# VISION SERVICE REPORT

P.O. Box 9907
Columbus, Georgia 31908-6007

An Independent Licensee of the Blue Cross Blue Shield Association

MEMBER I.D. CARD (INCLUDE ANY LETTERS)

MEMBER'S GROUP NO. OR GROUP NAME (INCLUDE ANY LETTERS)

## PATIENT INFORMATION

PATIENT LAST NAME | FIRST

# DIAGNOSIS V 720

PATIENT STREET ADDRESS

CITY | STATE | ZIP CODE

HOME PHONE | PATIENT'S SEX M F | PATIENT'S DATE OF BIRTH | PATIENT'S RELATIONSHIP TO MEMBER: 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.

Authorized Person's Signature | Date

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

Authorized Person's Signature

## TO BE COMPLETED BY PROVIDER

| 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 →

## PROVIDER

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

H-AAP-01410-06/02