



CLAIM FORM
(FOR VISION SERVICES)

EMPLOYER NAME :			
EMPLOYEE NAME :		LIFETIME BENEFIT SOLUTIONS ID#:	
LAST	FIRST	MI	<i>(ID # can be found on your ID card)</i>
PATIENT'S NAME (IF DIFFERENT FROM ABOVE) :		PATIENT'S DATE OF BIRTH	
LAST	FIRST	MI	
ARE YOU OR ANY OF YOUR DEPENDENTS COVERED UNDER ANOTHER PLAN?			<input type="checkbox"/> Yes <input type="checkbox"/> No
			If "YES," please provide the name of the Plan.
IF YES, NAME OF PLAN:			
REMIT PAYMENT TO: <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> PROVIDER			

MAKE SURE ALL ENCLOSED BILLS LIST

- ❖ DATE(S) OF SERVICE
- ❖ ITEMIZED CHARGES ("BALANCE BILL" STATEMENTS CANNOT BE PROCESSED)
- ❖ DIAGNOSIS CODE
- ❖ NAME OF PROVIDER

EMPLOYEE SIGNATURE

DATE

Please print and return this form with documentation to the address displayed on the back of your benefit ID card for processing.

Doing business as LBS Administrators and Flexible Benefit Insurance Solutions in California. Doing business as LBS Administrators in New Hampshire.