CLAIM FORM
(FOR VISION SERVICES)

EMPLOYER NAME :			
EMPLOYEE NAME :			**LIFETIME BENEFIT SOLUTIONS ID#:**
LAST	FIRST	MI	*(ID # can be found on your ID card)*
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? ☐ Yes ☐ No			If "YES," please provide the name of the Plan.
IF YES, NAME OF PLAN:			
REMIT PAYMENT TO: ☐ EMPLOYEE ☐ 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.