



Allied Benefit Systems, Inc.
 PO Box 909786-60690
 Chicago, IL 60690
 Phone: (800) 288-2078
 Fax: (312) 906-8359

Vision Claim Form

Please complete the applicable items in Part 1 and give the form your Provider and Dispenser to complete Parts 2 and 3. Please return the completed form to Allied Benefit Systems Inc. Please submit an itemized bill along with this claim form.

Part 1: To be completed by Employee/Patient

Employer Information	
Employer Name	Group Number

Employee Information			
Employee Name	Social Security Number	Birthdate	
Employee Address	City	State	Zip

Do you or any of your dependents have other group vision coverage?
 Yes (please provide information below) No

Name of Individual with other coverage	Other Insurance Carrier or TPA		
Address of Carrier or TPA	City	State	Zip

Patient Information		
Patient Name	Gender	Birthdate
Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:		

Claim Information	
Was this claim due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what was the date of the accident?
Where did the accident occur?	Is this claim the result of a work related illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No

Provider Information			
Provider Name	Patient Name	Date of Service	Total Charge

Employee Authorization	
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of vision treatment.	
Employee Signature	Date
ASSIGNMENT OF BENEFITS: I hereby authorize payment to the provider of vision services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.	
Employee Signature	Date

Part 2: To be completed by doctor, examining ophthalmologist or optometrist

Diagnosis or nature of disease, injury or vision disorder	Is condition due to patient's employment? [] Yes [] No
If yes, please explain	
Did the patient have glasses prior to examination [] Yes [] No	If yes, what type? [] Conventional [] Contacts
Does the patient require a lens prescription change? [] Yes [] No	If yes, please explain
Materials prescribed (please check all that apply) and indicate the number prescribed: [] Frames: _____ [] Single Vision: _____ [] Bifocal: _____ [] Trifocal: _____ [] Contacts: _____ [] Other: _____	
If prescribing tinted lenses, sunglasses, and/or safety glasses, please explain why:	

Report of Services (or attach itemized bill)

Provider Name	Provider Tax ID	Date of Service	Description of Service	Patient Name
Total Charge	\$			
Total Patient Paid	\$			
Total Reimbursement Request	\$			

Part 3: To be completed by dispenser of prescription (or attach itemized statement)

Date of Delivery	Fee for Lenses	Fee for Frames	Fee for Contacts	
	\$	\$	\$	
Full Name	Degree		Telephone Number	
Address	City		State	Zip

Dispenser Signature _____

Date _____

THE FOLLOWING MUST BE FURNISHED UNDER AUTHORITY OF LAW

Individual Practitioners SSN	All Others Federal Tax ID Number
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Part 4 - Additional Comments