



Vision Care Claim Form

*To be completed by the member **AND** the service provider (or attach itemized bill).
 For reimbursement, the member must file the claim with SAMBA.*

Section 1 Member and Patient Information – to be completed by the member			
Member Name (<i>Last, First, MI</i>)	Member ID	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date
Member Address (<i>Street, City, State, Zip</i>)			Daytime Telephone
Patient Name (<i>Last, First, MI</i>)	Patient's relationship to member <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date
Patient Address (<i>Street, City, State, Zip</i>)			
Is this claim covered by any other group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide member name (<i>Last, First, MI</i>) If yes, provide other group insurance carrier name and address		Policy Number
I acknowledge that the services listed below were received by me or my covered dependents. I authorize release of any information related to this claim to the Plan and any of its authorized representatives. Any reimbursement will be paid to the member.			
Member's Signature _____			Date _____

Section 2 Exam Information – to be completed by ophthalmologist/optometrist or attach itemized bill							
Date of Service	Diagnosis	Type of Exam <input type="checkbox"/> Eyeglasses <input type="checkbox"/> Daily Wear Contacts <input type="checkbox"/> Extended Wear Contacts				Exam Fee \$	
Date Ordered		Sphere	Cylinder	Axis	Prism	Add	Dilation <input type="checkbox"/> Yes <input type="checkbox"/> No
	L						<input type="checkbox"/> No
	R						\$
Provider Name		Provider Address (<i>Street, City, State, Zip</i>)				Provider Telephone	
Provider/Representative Signature				Provider FTIN		Date	

Section 3 Materials – to be completed by provider of service/optician or attach itemized bill			
Frames - Retail Amount \$ _____		Date of Purchase	DO NOT MARK IN THE BOXES BELOW.
Lens Type	Options		Contacts
Retail	Retail	Retail	Retail
<input type="checkbox"/> Single Vision \$ _____	<input type="checkbox"/> Polycarbonate \$ _____	<input type="checkbox"/> Solid Tint \$ _____	<input type="checkbox"/> Hard \$ _____
<input type="checkbox"/> Bifocal \$ _____	<input type="checkbox"/> Progressive \$ _____	<input type="checkbox"/> Gradient Tint \$ _____	<input type="checkbox"/> Soft \$ _____
<input type="checkbox"/> Trifocal \$ _____	<input type="checkbox"/> Scratch Coating \$ _____	<input type="checkbox"/> Photochromic \$ _____	<input type="checkbox"/> Daily Wear \$ _____
<input type="checkbox"/> Lenticular \$ _____	<input type="checkbox"/> Glass \$ _____	<input type="checkbox"/> A/R Coating \$ _____	<input type="checkbox"/> Extend Wear \$ _____
<input type="checkbox"/> Other \$ _____	<input type="checkbox"/> Ultra-Violet Coating \$ _____	<input type="checkbox"/> Other \$ _____	<input type="checkbox"/> Other \$ _____
Provider Name		Provider Address (<i>Street, City, State, Zip</i>)	Provider Telephone
Provider/Representative Signature		Provider FTIN	Date