MUTUAL
HEALTH SERVICES™

P.O. Box 5700 ♦ Cleveland, Ohio 44101
800-367-3762 ♦ Fax (330) 666-6685

STATEMENT OF CLAIM FOR VISION CARE

NOTE: COMPLETE THE SECTION BELOW. IF YOU ARE REQUESTING REIMBURSEMENT, OBTAIN FROM THE DOCTOR ITEMIZED BILLS SHOWING THE NAME OF THE PATIENT, DATE OF SERVICE, THE CHARGES AND EXACTLY WHAT THE CHARGES WERE FOR. SUBMIT THIS FORM AND THE BILL TO THE ABOVE ADDRESS. REIMBURSEMENT WILL BE ACCORDING TO YOUR PLAN SCHEDULE OF BENEFITS. IF YOU WANT PAYMENT MADE DIRECTLY TO THE DOCTOR, PLEASE HAVE THE BOTTOM OF THIS FORM COMPLETED BY THE PROVIDER.

TO BE COMPLETED BY EMPLOYEE

1. PRINT FULL NAME
2. HOME ADDRESS
3. CITY STATE ZIP CODE

COMPLETE ONLY IF A DEPENDENT CLAIM

FULL NAME OF DEPENDENT
BIRTHDATE
RELATIONSHIP OF PATIENT

4. Were any of the expenses covered by Workers' Compensation? ☐ YES ☐ NO
5. Is the person for whom claim is being made covered under any other vision care plan? ☐ Yes ☐ No

If Yes, name and address of other company: _____

The above answers are true to the best of my knowledge. I hereby authorize any doctor or optician, any insurance company or other organization to release any information required, including benefits paid or payable.

DATE _____ EMPLOYEE'S SIGNATURE _____

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE FOR DIRECT PAYMENT OF BENEFITS TO THE OPTOMETRIST OR OPTHALMOLOGIST. (*This assignment may be honored if signed by a dependent or person other than the employee.*)

DATED: _____ SIGNED: _____

TO BE COMPLETED BY EXAMINING DOCTOR (*Optometrist or Opthalmologist*)

1. NAME OF PATIENT EXAMINED _____ DATE OF EXAMINATION _____
2. CHARGE OF EXAM $ _____ TONOMETRY YES _____ NO _____
3. DOCTOR'S NAME _____ (PLEASE PRINT) _____ (DOCTOR'S SIGNATURE)

ADDRESS _____

TELEPHONE _____

TO BE COMPLETED BY SUPPLIER OF LENSES AND/OR FRAMES (*Optometrist or Optician*)

1. NAME OF PERSON FOR WHOM GLASSES WERE FURNISHED _____ DATE GLASSES PROVIDED _____
2. CHARGE FOR LENSES

Single Vision L ☐ R ☐	Trifocal L ☐ R ☐	Lenticular L ☐ R ☐
Bifocal L ☐ R ☐	Contacts L ☐ R ☐	

Materials: L $ R $	Extras: L $ R $	Tax: L$ R$

3. CHARGE FOR FRAMES:

Material: $ _____ Extras: $ _____ TAX: $ _____

INDIVIDUAL PRACTIONERS: SS Number: _____ - _____ - _____

ALL OTHERS: Employer ID Number: _____ - _____

4. OPTICIAN AGENCY NAME: _____ SIGNATURE: _____

1/13/13