

VISION/EYE CARE CLAIM FORM



PATIENT AND SUBSCRIBER INFORMATION						
1. PATIENT'S NAME (First, Middle Initial, Last Name)		2. PATIENT'S DATE OF BIRTH		3. SUBSCRIBER'S NAME First, Middle Initial, Last Name)		
4. PATIENT'S OTHER INSURANCE INFORMATION <small>IS PATIENT COVERED UNDER OTHER INSURANCE? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, NAME OF INSURANCE CO.</small>		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. SUBSCRIBER'S ID NUMBER		
IS PATIENT COVERED UNDER MEDICARE? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, PART A <input type="checkbox"/> PART B <input type="checkbox"/> NAME OF POLICY HOLDER (INCLUDING MEDICARE)		7. RELATIONSHIP TO SUBSCRIBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. SUBSCRIBER'S GROUP NUMBER OR ENROLLMENT CODE		
INSURANCE OR HIC NUMBER		9. WAS CONDITION DUE TO: WORK? YES <input type="checkbox"/> NO <input type="checkbox"/> AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> ANOTHER PARTY AT FAULT? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, ATTACH DETAILS		10. SUBSCRIBER'S ADDRESS CHECK IF NEW ADDRESS <input type="checkbox"/> STREET CITY STATE ZIP		
11. I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION REQUIRED TO REVIEW AND PROCESS THIS CLAIM.						
SIGNATURE OF SUBSCRIBER OR SPOUSE		DAYTIME TELEPHONE NO. ()		DATE		
12. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS (SEE REVERSE) I, THE UNDERSIGNED, AUTHORIZE AND REQUEST CAREFIRST BLUECROSS BLUESHIELD TO MAKE PAYMENT FOR BENEFITS DUE HEREIN TO:						
NAME OF PROVIDER		PROVIDER'S TAX OR SOCIAL SECURITY NUMBER		SIGNATURE OF SUBSCRIBER OR SPOUSE		DATE
PROVIDER INFORMATION: TYPE OR PRINT. ITEMS 13-36 MUST BE COMPLETED BY THE PROVIDER						
13. ICD - 9 - CM DIAGNOSIS CODE(S) OR BRIEFLY DESCRIBE CONDITION			14. DATE PRESCRIPTION LENS ORDERED BY PATIENT		15. DATE OF INJURY (Accident or Onset)	
16. WERE NEW LENSES PRESCRIBED? YES <input type="checkbox"/> NO <input type="checkbox"/>			17. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? IF YES, DATE OF ONSET YES <input type="checkbox"/> NO <input type="checkbox"/>		18. FOR SERVICES RELATED TO HOSPITALIZATION, DATE HOSPITALIZED ADMITTED DISCHARGED	
19. LENSES: Glass <input type="checkbox"/> Plastic <input type="checkbox"/> Other <input type="checkbox"/>			20. PATIENT RX: SPHERICAL R: L:		CYLINDRICAL R: L:	
21. LENSES: Executive <input type="checkbox"/> Flattop <input type="checkbox"/> Other <input type="checkbox"/>			22. WAS THIS RX FOR SUNGLASSES?		23. REFERRAL - SEE ITEM 23 ON REVERSE <input type="checkbox"/> Exam resulted in referral <input type="checkbox"/> Exam resulted from referral <input type="checkbox"/> None of the above	
24. WERE LENSES OVERSIZED? YES <input type="checkbox"/> NO <input type="checkbox"/>			26. LAST VISION EXAM DATE		27. CATARACT SURGERY DATE	
25. WERE LENSES TINTED? None <input type="checkbox"/> Photogray <input type="checkbox"/> Other <input type="checkbox"/>			28. PROVIDER SPECIALTY Physician <input type="checkbox"/> OD <input type="checkbox"/> Optician <input type="checkbox"/>			
29. A DATES OF SERVICE		B PLACE OF SERVICE	C PROCEDURE CODE	D SERVICES OR SUPPLIES PROVIDED		E CHARGES
FIRST	LAST					FREQ
1		30	92004	An comprehensive examination and evaluation with initiation of diagnostic and treatment program		9M0
2		30	92002	An intermediate examination and evaluation with initiation of diagnostic and treatment program		9M0
3		30	92081	Visual Field Examination with or without refraction		9M0
4		30	V2101	Half pair, single vision lens		9M0
5		30	V2201	Half pair, bifocal lens		9M0
6		30	V2301	Half pair, trifocal lens		9M0
7		30	92396	Supply of permanent prosthesis for aphakia, half pair, contact lenses		9M0
8		30	92391	Supply of contact lenses, half pair, except prosthesis for aphakia		9M0
9		30	V2020	Frames, purchase		9M0
10		30	V2115	Lenticular lens, per lens		9M0
11		30	92499	Not Otherwise Classified		9M0
12						9M0
30. PROVIDER'S NAME			31. PROVIDER'S TAX OR SSN		32. PROVIDER'S TELEPHONE NO.	
35. PROVIDER'S ADDRESS			36. SIGNATURE OF PROVIDER: I certify that the above services and/or supplies were provided by me or under my personal direction.		33. TOTAL CHARGE	
					34. OTHER INS. PD. AMT.	
					DATE	

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INSTRUCTIONS

THIS FORM IS USED TO SUBMIT A CLAIM FOR SERVICES UNDER YOUR HEALTH PLAN. TO AVOID HAVING YOUR CLAIM RETURNED:

- Prepare a SEPARATE CLAIM FORM for each family member.
- Complete ALL OF THE INFORMATION REQUESTED in items 1 through 11.
- Complete item 12 if you PREFER THAT BENEFITS BE PAID TO THE PROVIDER OF SERVICE. CareFirst BlueCross BlueShield reserves the right to make payment directly to the subscriber and to refuse to honor the assignment of any claim to any person or party.



Please complete Items 4, 6, and 8 as specified below:

- Item 4: If you also have any other health insurance coverage for Vision/Eye Care, complete item 4.
- Item 6: Indicate Identification Number as it appears on your Identification Card, or the subscriber's Social Security Number.
- Item 8: Indicate the Group Number from your Identification Card.

PROVIDER INFORMATION

The provider is to complete items 13 through 36 as indicated. The following Items are to be completed as specified below. If the provider does not complete the reverse side, a completely itemized bill must be attached.

- Item 23: Complete with the name of the provider who referred the patient to you or the name of the provider to whom you referred the patient.
- Item 29D: If the service or supply which you provided is preprinted under 29D, please complete the date of service, the place of service if appropriate, the charge and the frequency. If the service or supply which you provided is not printed under 29D, please complete the blank line under Item 29.
- Item 29D.3: Visual field examination with diagnostic evaluation; with or without refraction; examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
- Item 29F: Unless otherwise indicated by the procedural description, the frequency of supplies is important when billing for one or more lenses. Use this to indicate the number of lenses or the frequency of each specified code.
- Item 36: If the claim form is being used in place of an itemized bill, the provider must sign and date the claim in item 36.

BEFORE SUBMITTING YOUR CLAIM, PLEASE BE SURE THAT:

1. The subscriber has completed items 1-11 and item 12, if applicable.
2. The provider has completed items 13-36 or a completely itemized bill is attached.
3. You have kept copies of the claim for your personal records, if needed.

Vision/Eye Care Program subscriber claims should be submitted to:

Mail Administrator
P.O. Box 14115
Lexington, KY 40512-4115