Mail Claim Form 10:





VISION CLAIM FORM

PART I PATIENT AND CERTIFICATE HOLDER INFORMATION				(please print or type)		
Certificate Holder's name		7. Patient's relation to Certificate Holder		10. **IMPORTANT** If the patient is covered by any other group or non-group health insurance, including Medical Mutual, please complete this section. Name of other employer		
Address						
State Zip		1 🗆	(male) (female) husband 1 □ 2 □ 3 □		Address of other employer	
Phone ()		4 🗆				
3. Certificate Holder's ID number:		depend			If the patient is a child and parent's are divorced, please answer the following: a. Which parent has custody of the patient?	
Medical Mutual Plan code:		19 years	8. Is patient full-time'student 19 years of age or older? yes no		b. Is there a court decree that states which parent is responsible for medical bills? yes no. If yes, please attach a copy of the court decree. 11. Is the patient eligible for Medicare? yes no	
(Numbers can be found on Certificate Holder's ID card 4. Group name:		Name of school:		12. Describe the illness, injury or symptom:		
Group number: 5a. I authorize release of any information relative to this		9. Was condition related to: A. Employment □ yes □ no B. Accident □ yes □ no				
		Date	of Onset:	1	irst appeared:	
PART II PHYSICIAN OR PR		ertificate Holder o	or Spouse)		DATE:	
OFFICE SERVICES		OPTICAL CHARG		(Date of service		
Date of examination//		Lens	(L) Acquis	ition fee (R)	(L) Dispensing fee (R)	
Service Description	FEES	Single vision Bifocal Trifocal				
		Lenticular Tint				
		Type Photochromatic Contact lenses			'	
TOTAL OFFICE FEES		Frames				
Refraction yes_ no		Options		· · · · · · · · · · · · · · · · · · ·		
OPTICAL STYLE Glass Plastic One eye Both eyes	☐ Other		-	SUBTOTAL:		
CONTACT LENSES				TAX:		
☐ Due to cataract surgery ☐ Oth ☐ To obtain 20/70 vision	ner		OPTICAL CHARGE	S TOTAL:		
	I certify that the services were performed by me or in my presence under my supervision.	Address	ovider name	State	Zip	
MED/SURG 006 R5/88 Z5004 R6/01 Medical Mutual of Ohio®		Signature			Medical Mutual Services, L.L.Ç.	

FOR THE CERTIFICATE HOLDER

- 1. Use this form for all your vision claims. Use a separate form for each patient and each physician.
- 2. Complete all items on Part I of the form for both the patient and the Certificate Holder. If any information is missing a delay in processing will result. Make sure you sign the form in Block #5A to authorize release of information.
- 3. After completion of Part I give the form to your physician or provider.

FOR THE PHYSICIAN OR PROVIDER.

- 1. Use a separate claim form for each patient and each provider rendering service.
- Review the top of the form to make sure the employee has provided all information, especially Coordination of Benefits (Block 10) and a signature (Block 5A). Missing information will cause a detay in processing.
- 3. Complete Part II with all information pertinent to the patient's treatment.
- 4. Be sure to use your taxpayer ID number.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)