ALL INFORMATION
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IS CONFIDENTIAL

# GENERIC VISION CARE CLAIM FORM

CLAIMSECURE INC.
43 ELM STREET, SUITE 200,
SUDBURY, ONTARIO P3C 1S4
1-888-513-4464

## IDENTIFICATION OF THE INSURED

| Last Name | First Name |
|---|---|
| Address | Apt. |
| City | Province |
| Telephone | Postal Code |
| Date of Birth (YYYY/MM/DD) | Employee Cert./SIN/ID No. |
| Policy/Group/Plan No. | Account No./Division/Section |
| Insurance Company | Employer Name |

## IDENTIFICATION OF THE PATIENT

| Last Name | First Name |
|---|---|
| If Patient address is different – please complete: | |
| | |
| Patient Identification Number | Date of Birth (YYYY/MM/DD) |

Relationship with the insured ❏ PLAN MEMBER ❏ DEPENDENT ❏ SPOUSE ❏ SPECIAL DEPENDENT ❏ STUDENT

NAME OF EDUCATIONAL INSTITUTION IF APPLICABLE:

## IDENTIFICATION OF THE PROVIDER

| Name | |
|---|---|
| | |
| Address | |
| City | Province |
| Telephone | Postal Code |
| Permit No./License No. | Insurance Carrier Provider No. |

## SPOUSE/ALTERNATE COVERAGE – COORDINATION OF BENEFITS

WCB/WSIB? ❏ Yes ❏ No
Do you have other Vision Care coverage? ❏ Yes ❏ No

If yes, please complete the following:
Name of Insurer/Plan ________ Name of Insured ________
Effective Date of Coverage (YYYY/MM/DD) ________

Policy/Group/Plan No. ________ Coverage ❏ Family ❏ Single
Alternate coverage/Employee Cert./SIN/ID No. ________
Spouse or Alternate Date of Birth (YYYY/MM/DD) ________
If this is your first claim, or if information has changed, please specify:

Either a copy of the payment or denial letter from the primary carrier must be attached.

## DETAILS OF THE PRESCRIPTION

| | | Sphere | Cylinder | Axis | Prism | Add |
|---|---|---|---|---|---|---|
| **New Rx** | Right | | | | | |
| | Left | | | | | |
| **Old Rx** | Right | | | | | |
| | Left | | | | | |

Plastic ❏ Type of right lens ________
Hardened ❏ chem Type of left lens ________
❏ Heat Tint ________
Oversize: ________ mm

❏ initial prescription ❏ prescription sunglasses ❏ Rx duplicate
❏ new prescription ❏ contact lenses ❏ replacement (loss or breakage)
❏ safety glasses ❏ lenses only
❏ post cataract
❏ other: (indicate any medical conditions or disease) ________

If claim is for contact lenses:
Can visual acuity be restored to ❏ 20/70? ❏ 20/40?
Are the contact lenses medically necessary due to keratocunus, irregular astigmatism, aphakias, or irregular corneal curvature? ❏ Yes ❏ No
Can visual acuity be improved by at least two lines on the Snelian chart over the best possible vision with glasses? ❏ Yes ❏ No

## CLAIM DETAILS

Please attach copies of the original Paid in Full receipt if claim payable to Insurer

| DISPENSING DATE YYYY/MM/DD | SERVICE CODE | SERVICE DESCRIPTION (When required, specify dispensing fees separately.) | Quantity | Dispensing Fee | Price |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | Total $ | |
| | | | | Patient Paid $ | |

**ASSIGNMENT DETAILS:**
I hereby assign my benefits payable from this claim and authorize payment directly to the above Service Provider
*Insured's signature* ________

**CONTRACT HOLDER/ADMINISTRATOR DETAILS:**
Dates (YYYY/MM/DD) Eligible ________
Dependent Eligible ________
Terminated ________
Is treatment the result of an occupational illness or injury, or otherwise related to employment? ❏ Yes ❏ No
Contract Holder and Location: ________
*Signature of Authorized Official:* ________ *Date:* ________
*Administrator Signature:* ________ (YYYY/MM/DD)

PICK UP DATE (YYYY/MM/DD) ________ | Balance to be paid to provider $

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member.

I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

A copy of this authorization shall be as valid as the original.

*Insured's signature:* ________ *Date:* ________

*Provider's signature:* ________ *Date:* ________