

HOW TO COMPLETE A VISION CLAIM FORM

Employee . . . Part I . . . Shaded Area

Answer **all** questions in blocks numbered 1 through 11. Sign and date block number 12. Your claim cannot be processed without your signature in this block. If you want the benefit issued to the physician or provider of service sign block number 13. If you have paid the provider of service do not sign block number 13. Have physician complete Part II.

Physician . . . Part II

Answer **all** questions in blocks numbered 1 through 12. If you are providing the complete service and materials continue through Part III, answering **all** questions in A through L and mail to the address on the front of this form.

Materials and Professional Services . . . Part III

Answer **all** questions A through L and mail to the address on the front of this form. If patient has paid the charges please indicate the amount in "TOTAL PAID."

If you have any questions please call the toll-free number on the front of this form. Submit claims to School Claims Service, LLC, P.O. Box 812, New Cumberland, PA 17070-0812.

EMPLOYER: If employer certification is required, please complete the following:

EMPLOYEE'S NAME (<i>Last, First and Middle Initial</i>)	DATE BENEFITS BECAME EFFECTIVE EMP Mo. Day Year DEP Mo. Day Year	DATE TERMINATED Mo. Day Year	IS EMPLOYEE <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED
EMPLOYER'S NAME	SIGNATURE OF AUTHORIZED PERSON		DATE Mo. Day Year