MAIL TO: CEBT/CNIC
P.O. Box 3559
Englewood, CO 80155-3559

VISION CARE CLAIM FORM
CEBT

Group: CEBT

Employee's Statement *(see instructions on other side)*

EMPLOYEE INFORMATION:

NAME (Last) (First) (Middle) | SOCIAL SECURITY NUMBER ___/___/___

ADDRESS (Street) (City) (Zip Code) | OCCUPATION:

DATE OF BIRTH (month, day, year) ___/___/___ | SEX ☐ M ☐ F | ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW(ER)

DEPENDENT INFORMATION: ***COMPLETE ONLY IF PATIENT IS A DEPENDENT***

DEPENDENT'S NAME | DATE OF BIRTH (mo. day yr.) ___/___/___ | RELATIONSHIP ☐ CHILD ☐ SPOUSE ☐ OTHER | IS CHILD-PATIENT EMPLOYED? ☐ YES ☐ NO ☐ PART-TIME ☐ FULL-TIME

SEX ☐ M ☐ F | ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW(ER) ☐ LEGALLY SEPARATED | IS CHILD-PATIENT OVER AGE 19 FULL TIME STUDENT? ☐ YES ☐ NO IF "YES", GIVE NAME & ADDRESS OF SCHOOL.

OTHER COVERAGE INFORMATION: *COMPLETE IN **ALL** CASES*

IS PATIENT COVERED BY ANY OTHER GROUP PLAN WHICH PROVIDES VISION CARE BENEFITS? ☐ YES ☐ NO | IF "YES", BY WHOM: (EMPLOYEE NAME, EMPLOYER NAME & ADDRESS & POLICY NO.)

All the above statements are true and complete to the best of my knowledge.

EMPLOYEE'S SIGNATURE **X** _____ (signature necessary on all claims) DATE SIGNED _____ month _____ day 19____ yr

SIGNATURE OF PATIENT **X** _____ (required only if patient is spouse) DATE SIGNED _____ month _____ day 19____ yr

EXAMINING PHYSICIAN OR OPTOMETRIST'S INFORMATION

Indicate Diagnosis or Nature of Disease, injury or Vision Disorder

Type of vision care patient had prior to this examination
☐ Conventional Lenses ☐ Contacts ☐ Low Vision Aids
☐ Visual Training/Vision Therapy ☐ Medication
State condition treated _____
Surgery (explain) _____

Describe conditions diagnoses which require treatment at this time

Does Patient require a prescription change at this time?
Frames ☐ YES ☐ NO Lenses ☐ YES ☐ NO
If yes, why?

Indicate date of patient's last change of: lenses _____ frames _____
Check the materials or treatment prescribed (note number prescribed): ☐ Frames _____
☐ Single Vision _____ ☐ Bifocal _____ ☐ Trifocal _____ ☐ Contact lens _____
☐ Low Vision aid _____ ☐ Visual Training/vision therapy _____ ☐ Other _____

If Contact Lenses, would the visual acuity be corrected to 20/70 in the better eye by use of Conventional Lenses? ☐ YES ☐ NO

If tinted lenses, photograys, sunglasses or conventional lenses are prescribed which are not impact-resistant, state reason why:

Report of services, or attach itemized bill. (If previous form submitted to this carrier, you need show only dates and services since last report)

Date of Service	Services Rendered	Charges	

Physician's or Optometrist's Name, Address, Zip Code, and Telephone No.

Social Security No.	Total Charges
Employer I.D. No.	Amount Paid
Other Identifying No.	Balance Due

Accept Assignment ☐ YES ☐ NO | Signature of Physician/Optometrist Sign Here | Date Signed | Your Patient's Account No.

AUTHORIZATION FOR DIRECT PAYMENT: *COMPLETE **ONLY** IF YOU WISH PAYMENT TO BE MADE DIRECTLY TO PHYSICIAN OR OPTOMETRIST*

I authorize payment of medical benefits for services rendered by (specify)_____

Date _____ Employee's Signature **X** _____

(over)

7/05

VISION CARE CLAIM INSTRUCTIONS

Check to see that all required information has been completed and that the form has been **signed.** Failure to completely fill out the form may **delay** payment of your claim.

FILING PROCEDURE:

Claim forms are available from the Administrative Offices.

A claim form should be submitted for **each member** of the family for whom claims are made. A claim form should be filled out **each time** bills are submitted.

Completed claim forms, together with **itemized bills,** are to be sent to CNIC (address below).

TIMELY CLAIMS SUBMISSION: All claims are required to be submitted within 12 months of the date of service. If claims are not submitted within these guidelines, payment will not be assured.

ITEMIZED BILLS:

Bills for services and treatment must include the information indicated below. Failure to submit complete bills will **delay** processing of your claim. Lists of expenses or statements of "Balance Due" are not acceptable.

Physician or Optometrists — Bills must show patient's name, date(s) of treatment, description of lenses and charges.

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NOTE: PROVIDERS—FOR INFORMATION, PLEASE CALL (303) 773-1373