MAIL OR FAX COMPLETED FORM TO ☛

NORTH AMERICA ADMINISTRATORS

P. O. Box 1984 • Nashville, TN 37202
1826 Elm Hill Pike • Nashville, TN 37210
Fax: 615-255-6654

naa | North America Administrators

Group Name:	Employee Name:	Social Security #:	
	Address:	Email:	
I Hereby Apply for Benefits for: ☐ Self ☐ Spouse ☐ Unmarried Child	Patient's Name:	Patient's Date of Birth: / /	FEMALE ☐ MALE ☐

Is Dependent a Student? ☐ Full Time ☐ Part Time	If so, name and address of school (Street, City, State and Zip Code)	Is Dependent carried as an income tax exemption? ☐ Yes ☐ No

Does any other employer or organization contribute to, make deductions for, or otherwise participate in any other group program in your or any of your dependent's behalf?
☐ Yes ☐ No If yes, give name of dependent _____

Name and address of plan:	Name and address of other plan:	Plan Number:

PATIENT'S AUTHORIZED PERSON'S SIGNATURE:	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED_____ DATE_____	I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED_____

TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST

First Correction?_____ Prescription Change: _____

One	Two		
☐	☐	Lenses - Single Vision	$_____
☐	☐	Lenses - Bifocal	$_____
☐	☐	Lenses - Trifocal	$_____
☐	☐	Lenses - Lenticular	$_____
☐	☐	Lenses - *Types of Contact Lens* ☐ Disposal ☐ Regular	
		TOTAL	$_____

Exam $_____
Frames $_____
TOTAL $_____ Date of Exam _____

_____
Doctor's Signature Degree Date

_____
Print or Type Doctor's Name

_____
Street Address

_____
City State Zip Telephone No.

TO BE COMPLETED BY DISPENSING OPTICIAN (OR ATTACH ITEMIZED BILL)

Frames_____

One	Two		
☐	☐	Lenses - Single Vision	$_____
☐	☐	Lenses - Bifocal	$_____
☐	☐	Lenses - Trifocal	$_____
☐	☐	Lenses - Lenticular	$_____
☐	☐	Lenses - Cosmetic Contact	
		TOTAL	$_____

Frames - Date of Service _____

LENS - Date of Service _____

_____
Provider's Signature Date

_____
Print or Type Provider's Name Tax ID #

_____
Street Address

_____
City State Zip Telephone No.