

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

Group Name:	Employee Name:	Social Security #:	
	Address:	Email:	
I Hereby Apply for Benefits for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Patient's Name:	Patient's Date of Birth: / /	FEMALE <input type="checkbox"/> MALE <input type="checkbox"/>
Does any other employer or organization contribute to, make deductions for, or otherwise participate in any other group program on your or any of your dependent's behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, give name of dependent _____			
Name and address of plan:	Name and address of other plan:	Plan Number:	

<p>PATIENT'S AUTHORIZED PERSON'S SIGNATURE:</p> <p>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.</p> <p>SIGNED _____ DATE _____</p>	<p>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:</p> <p>I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED _____</p>
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TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST			
First Correction? _____ Prescription Change: _____			
<p>One Two</p> <p><input type="checkbox"/> <input type="checkbox"/> Lenses - Single Vision \$ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Lenses - Bifocal \$ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Lenses - Trifocal \$ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Lenses - Lenticular \$ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Lenses - _____</p> <p><i>Types of Contact Lens</i></p> <p><input type="checkbox"/> Disposal    <input type="checkbox"/> Regular</p> <p>TOTAL \$ _____</p> <p>Exam \$ _____</p> <p>Frames \$ _____</p> <p>TOTAL \$ _____ Date of Exam _____</p>	<p>Doctor's Signature _____ Degree _____ Date _____</p> <p>Print or Type Doctor's Name _____</p> <p>Street Address _____</p> <p>City _____ State _____ Zip _____ Telephone No. _____</p>		

TO BE COMPLETED BY DISPENSING OPTICIAN (OR ATTACH ITEMIZED BILL)			
Frames _____			
<p>One Two</p> <p><input type="checkbox"/> <input type="checkbox"/> Lenses - Single Vision \$ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Lenses - Bifocal \$ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Lenses - Trifocal \$ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Lenses - Lenticular \$ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Lenses - Cosmetic Contact</p> <p>TOTAL \$ _____</p> <p>Frames - Date of Service _____</p> <p>LENS - Date of Service _____</p>	<p>Provider's Signature _____ Date _____</p> <p>Print or Type Provider's Name _____ Tax ID # _____</p> <p>Street Address _____</p> <p>City _____ State _____ Zip _____ Telephone No. _____</p>		