PLYMOUTH-CANTON COMMUNITY SCHOOLS
PLAN NO.: 0929
VISION CLAIM FORM

MAIL TO: MERITAIN HEALTH
P.O. Box 30132
Lansing, MI 48909

EMPLOYEE INFORMATION

NAME:

ADDRESS:

PHONE: ( )

SOCIAL SECURITY NO.

Is patient covered by other VISION insurance? ☐ Yes ☐ No

Insured's Name:_____

Name of Employer providing the Vision Insurance: _____

_____

Name of Insurance Company: _____

Policy No.:_____

I authorize payment of VISION benefits to the physician or supplier of services.

_____
Signed (Patient or Authorized Person)

DATE OF EXAMINATION | $

DOCTOR'S SIGNATURE

DOCTOR'S SOCIAL SECURITY NO.(TAX ID NO.)

LENSES & FRAMES| DATE OF PURCHASE:

SINGLE VISION 821		BIFOCAL 822		TRIFOCAL 823	
LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
$	$	$	$	$	$

LENTICULAR 824		FRAMES 830		CONTACT LENS 835	
LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
$	$	$	$	$	$

PATIENT INFORMATION

PATIENT NAME (First, Middle, Last) | RELATIONSHIP | SEX | BIRTH DATE
| ☐ Self ☐ Spouse| F M | MO/ DAY/ YR
| ☐ Child ☐ Other | ☐ ☐ |

PATIENT'S ADDRESS (If different that Employee's)

Is the patient a full-time student? ☐ Yes ☐ No
If Yes, Name of School:

Was condition related to: | If an accident - give date:

A. Patient's employment? | Description (how and where):
☐ Yes ☐ No

B. An accident?
☐ Yes ☐ No

I authorize the release of any VISION information relating to this claim.

_____
Signed (Patient or Authorized Person) Date

DOCTOR'S NAME

ADDRESS

OPTICAL COMPANY'S NAME

ADDRESS

OPTICAL COMPANY'S TAX ID NO.

HAS THERE BEEN A CHANGE IN PRESCRIPTION?
☐YES ☐NO

PLEASE READ CAREFULLY:

1) Use this form when you are sending vision bills for payment. The provider of services does not have to complete this form unless they desire to do so.
2) **COMPLETE** the **EMPLOYEE** and **PATIENT INFORMATION.**
3) **SIGN** the authorization portion to release medical information.
4) More than one bill can be sent with this form providing all bills are for the patient mentioned above.
5) Be sure all bills are **ITEMIZED**. An itemized bill must include:
   A. Patient's name.
   B. Date of service.
   C. Services rendered.
   D. Amount charged for each service.
   E. **DIAGNOSIS**.

ACCIDENTS: BE SURE TO INDICATE **WHEN, WHERE, AND HOW** THE ACCIDENT HAPPENED.

MERITAIN HEALTH 1-800-748-0003