Employer Funded Plan

The Health Plan
52160 National Road East
St. Clairsville, Ohio 43950-9365
Telephone: (740)695-3585
Toll Free: 1-800-624-6961
www.healthplan.org

VISION BENEFITS CLAIM FORM

Please submit your billing along with this claim form to our Plan Administrator at:
Allied Services Division of The Health Plan
52160 National Road
St. Clairsville, OH 43950
888-816-3096

EMPLOYER: OHIO COUNTY SCHOOLS GROUP #01809820

TYPE OR PRINT

PATIENT & INSURED (SUBSCRIBER) INFORMATION		
1. PATIENT'S NAME (First, Middle initial, Last Name)	2. PATIENTS DATE OF BIRTH	3. INSURED'S NAME (First, Middle initial, Last Name)
4. PATIENT'S ADDRESS (Street, City, State, Zip code)	5. PATIENT'S GENDER MALE FEMALE 7. Patient's relationship to insured Self Spouse Child	6. INSURED'S I.D. NUMBER 8. INSURED'S GROUP NUMBER (OR GROUP NAME)
9. OTHER HEALTH INSURABCE COVERAGE--Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES NO B. AN AUTO ACCIDENT YES NO	11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any Medical information necessary to process this claim and request payment of Medicare Champus benefits either to myself or to the party who accepts assignment below SIGNED DATE		13. I authorize payment of Medical Benefits to undersigned physician or supplier for services described below SIGNED

Did visual analysis indicate a change in prescription from the immediately preceding prescription? ☐ YES ☐ NO

SERVICES **CHARGES**

EXAM
Date of Service_____ $_____

LENSES
Date of Service_____ $_____

Type of Lenses	Was Lens
☐ Single	☐ Tinted
☐ Bifocal	☐ Sunglasses and/or Safety Glasses
☐ Trifocal	☐ Other_____

FRAMES
Date of Service_____ $_____

CONTACTS
Date of Service_____ $_____

Please advise reason for contacts (severe corneal astigmatism, severe corneal scarring, or patient prefers contacts etc.)_____

TOTAL $_____

NDIVIDUAL PRACTIONERS-SS# ☐☐☐
ALL OTHERS-EMPLOYER IRS# ☐☐
Must be furnished under authority of law

AMOUNT PAID $_____

BALANCE DUE $_____

Date Physician's Name Signature

Street Address City or Town State Zip Code