Blue Shield of California and Blue Shield of California Life & Health Insurance Company – Vision claim form

Please forward claims to: Blue Shield of California, P.O. Box 25208, Santa Ana, CA 92799-5208. **(877) 601-9083** members or **(800) 877-6372** providers. The participating provider must obtain an Eligibility Verification Number from MESVision. **For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison. Note:** Please complete the entire form. This form cannot be processed if information is incomplete. **Important: Please print all sections in black ink.**

INSURED / PATIENT PORTION

PATIENT'S NAME (Last Name, First)

GENDER ☐ MALE ☐ FEMALE

EMPLOYEE'S IDENTIFICATION NO.

EMPLOYEE'S NAME

RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ DOMESTIC PARTNER ☐ DOMICILED ADULT ☐ DISABLED

PATIENT'S BIRTHDATE MONTH DAY YEAR / /

ADDRESS

NAME OF EMPLOYER

GROUP POLICY NUMBER

CITY, STATE, and ZIP CODE

WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS? ☐ NO ☐ YES

IF "YES," PLEASE EXPLAIN:

E-MAIL

IS PATIENT FULL-TIME STUDENT? ☐ NO ☐ YES SCHOOL NAME:

OTHER VISION COVERAGE? IF "YES," GIVE NAME OF CARRIER AND POLICY NUMBER ☐ YES ☐ NO

POLICY NUMBER:

NAME OF CARRIER:

The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize my doctor to furnish and disclose all facts concerning this claim. I hereby assign payable benefits to participating providers.

SIGNATURE **DATE**

EXAMINER / DISPENSER PORTION

VERIFICATION #:

CHECK CONDITIONS PATIENT IS KNOWN TO HAVE
☐ DIABETES ☐ HIGH CHOLESTEROL ☐ HYPERTENSION ☐ GLAUCOMA

DIALATION : ☐ YES ☐ NO

RETINAL PHOTOS : ☐ YES ☐ NO

PRESCRIBED
☐ **Single Vision** ☐ **Bifocal** ☐ **Trifocal** ☐ **Progressive** ☐ **Contacts**

Rx	Sphere	Cylinder	Axis	Prism	Base Curve
R.E.					
L.E.					

READING ADD R.E. + L.E. +

EXAM DATE: MONTH DAY YEAR / /

CL FITTING DATE: MONTH DAY YEAR / /

OTHER CONDITIONS/ DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD 9 / 10 Codes)

Diagnosis : ____ . ____ Diagnosis : ____ . ____

Diagnosis : ____ . ____ Diagnosis : ____ . ____

HCPC/CPT CODES	CHARGES
	$
	$
	$
	$
TOTAL EXAM CHARGES	$ 0.00

NAME OF DOCTOR PARTICIPATING PROVIDER NO.

EMAIL ADDRESS NPI NO.

ADDRESS

CITY, STATE and ZIP CODE

SIGNATURE DATE

VERIFICATION #:

DATE OF ORDER: MONTH DAY YEAR / /

DELIVERY DATE: MONTH DAY YEAR / /

HCPC/CPT CODES	EYEWEAR	CHARGE
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
	L ☐ R ☐	$
FRAME IS FRAME SIZE LESS THAN ☐ 56 ☐ 61		$
PLANO SUNGLASSES (PRE FABRICATED / NON-RX)	PROOF OF LASIK SURGERY MAY BE REQUIRED FOR SUNGLASS BENEFIT	$
CONTACTS (CL)		$
CL MANUFACTURER	CL BRAND	NO. OF CL BOXES
COB: List the total overage on this line COB itemized charges above must be patient out of pocket		$
TOTAL FOR OPTICAL MATERIALS		$ 0.00

NAME OF DISPENSER PARTICIPATING PROVIDER NO.

EMAIL ADDRESS NPI NO.

ADDRESS

CITY, STATE and ZIP CODE

SIGNATURE DATE

Rev 2018

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