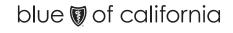
Blue Shield of California and Blue Shield of California Life & Health Insurance Company – Vision claim form



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 call MESVision to obtain an Eligibility Verification Number. 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.

	PATIENT'S NAME	(Last Name, Fi	rst)					GENDER			EMPLO	YEE'S IDENTIFICATION NO.	
_								☐ MAI	LE	FEMALE		EMI ESTEES IDENTIFICATION NO.	
Ó	EMPLOYEE'S NAM	MPLOYEE'S NAME							ATIONSHIP TO EMP	PATIENT'S BIRTHDATE MONTH DAY YEAR			
RT	ADDRESS								SPOUSE	1 1			
PORTION	ABUNEOU							DOMESTIC	NAME OF EMPLOY		DISABLED GF	/ / ROUP POLICY NUMBER	
	CITY, STATE, and ZIP CODE												
Ä								WAS CARE REQUIRED BECAUSE OF AN INJURY OR ILLNESS? IF "YES," PLEASE EXPLAIN:					
	LIVIAIL								NOYES				
/ PATIENT													
	OTHER VISION COVERAGE? IF "YES," GIVE NAME OF CARRIER AND POLICY NUMBER YES NO NO							POLICY NUMBER: NAME OF CARRIER:					
뀖	The above answers are true and complete according to the best of my kno									l horoby authoriza	my doctor to fur	nich and	
INSURED	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					
_													
	VERIFICATION #:							VERIFI	CATION #:				
	CHECK CONDITIONS PATIENT IS KNOWN TO HAVE							DATE OF OF		DAY YEAR	DELIVERY DATI	MONTH DAY YEAR	
	DIABETES HIGH CHOLESTEROL HYPERTENSION GLAUCOMA								/	/		/ /	
PORTION	OTHER CONDITIONS/ DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (ICD 9 / 10 Codes)						ii lo codes)	HCPC/C	PT CODES	EYEV	VEAR	CHARGE	
	Diagnosis: Diag				iagnosis :					L 🗆	R □	\$	
	Diagnosis :	Diagnosis :					L 🗆	R□	\$				
	PRESCRIBED						_			L	R □	\$	
	∐ Single Vis Rx	Single Vision Bifocal Tri				Prism	Base Curve				 R □	·	
	R.E.							-				\$	
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	j	READING ADD R.E.		L.E.		+				L 🗌	R 🗌	\$	
	EXAM	XAM MONTH DAY YEAR		CL FITTING MONTH DAY YEAR					L 🗆	R□	\$		
DISPENSER	DATE: HCP	DATE: / / CHARGES						L 🗆	R □	\$			
ISPI	ПСР					001	IT A OTO	BRAND		·			
/ D		\$				CON	ITACTS	EDAME AUMADED		\$			
JER.		\$					RAME SIZE LESS THAN	FRAME NUMBER 56 61		\$			
EXAMINER /					\$				UNGLASSES CATED / NON-RX)	PROOF OF LASIK S REQUIRED FOR SU	URGERY MAY BE NGLASS BENEFIT	\$	
ΕX	\$							COB: List the total overage COB itemized charges above must be				\$	
	TOTAL EXAM CHARGES \$							TOTAL FOR OPTICAL MATERIALS				\$	
	NAME OF DOCTOR				PARTICIPATING PROVIDER NO.				ENSARY	PARTICIPATING PROVIDER NO.			
	EMAIL ADDRESS				N	PI NO.		EMAIL ADDRESS				NPI NO.	
	ADDRESS							ADDRESS					
	CITY, STATE and ZIP CODE							CITY, STATE and ZIP CODE					
	SIGNATURE DATE							SIGNATURE				DATE	