eye care
group claim form

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AMERITAS LIFE INSURANCE CORP.

PART 1 – TO BE COMPLETED BY EMPLOYEE

1. Patient's full name (first, middle initial, last)	2. Patient birthdate (MM/DD/YY)	3. Relationship to employee ☐ self ☐ spouse ☐ child ☐ other	4. Sex ☐ M ☐ F

5. Employee's full name (first, middle initial, last)	6. Employee's identification number	Employee's birthdate (MM/DD/YY)

7. Employee's mailing address (Street address or P.O. Box, City, State, ZIP) Email address	8. THIS SECTION MUST BE COMPLETED WITH **EACH** CLAIM SUBMISSION **ONLY** IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER Is patient a full-time student? ☐ Yes ☐ No If Yes, name and address of school

9. Employer (company) name and address	10. Group number	Division number	Certificate number

QUESTIONS 11 AND 12 MUST BE COMPLETED WITH **EACH** CLAIM SUBMISSION

11. Is patient covered by another eye care plan? ☐ Yes ☐ No	Name and address of other carrier	Policy number	Name and address of other employer

12. Other employee/subscriber name	Employee/subscriber identification number	Date of birth (MM/DD/YY)	Relationship to patient

13. **I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of treatment. I certify these statements to be true and complete to the best of my knowledge.**	14. **I hereby authorize payment directly to the below named provider of group insurance benefits otherwise payable to me.**
X _____ Signature (patient, or parent if minor) _____ Date	X _____ Signature (insured person) _____ Date

PART 2 – TO BE COMPLETED BY ATTENDING EYE CARE PROVIDER.

15. Eye care provider name and mailing address	**For Yes answers to questions 17-19, enter a brief description and date.**
	17. Is treatment result of occupational illness or injury? ☐ Yes ☐ No
	18. Is treatment result of auto accident? ☐ Yes ☐ No
Specialty / Phone number	19. Other accident? ☐ Yes ☐ No
Email / Fax number	20. This is a (please check one): ☐ Statement of actual services ☐ Pretreatment estimate
16. Federal tax ID number ☐ SSN ☐ TIN / NPI (National Provider Identifier)	21. Is this for LASIK/PRK? ☐ Yes ☐ No
License #	

22. EXAMINATION AND TREATMENT RECORD Please include date of service, description of services, procedure code and fee.

Date service performed (MM/DD/YY)	Description of services	CPT/HCPCS procedure code	Diagnosis code	LASIK PRK	Left eye	Right eye	Fee

23. Remarks

24. Total $

25. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.

X _____ Signature (Provider) _____ Date

26. Address where treatment was performed