EMI Health

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Vision Claim Form

TO BE COMPLETED BY MEMBER

PATIENT NAME	RELATIONSHIP TO EMPLOYEE	PATIENT BIRTHDATE
EMPLOYEE NAME	EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE PHONE
EMPLOYEE ADDRESS		
EMPLOYER NAME	IS PATIENT COVERED BY ANOTHER VISION PLAN?	OTHER VISION PLAN NAME
OTHER INSURANCE COMPANY NAME AND ADDRESS		

DO YOU WANT PAYMENT TO GO DIRECTLY TO THE PROVIDER?	I CERTIFY THAT THE INFORMATION ON THIS CLAIM IS CORRECT AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. SIGNED (PATIENT OR PARENT OF MINOR PATIENT):

TO BE COMPLETED BY DISPENSER

IN LIEU OF DISPENSER COMPLETING THIS SECTION, A LABORATORY BILL MAY BE ATTACHED.

DISPENSER NAME	TAX PAYER IDENTIFICATION NO.
DISPENSER ADDRESS	PHONE NUMBER

DISPENSER TITLE
- ❑ Opthalmologist
- ❑ Optician
- ❑ Optometrist

MATERIALS SUPPLIED
- Tint #_____
- ❑ Oversized
- ❑ Pair
- ❑ Glass
- ❑ Half pair
- ❑ Plastic
- ❑ Other _____

TYPES OF LENSES DISPENSED
- ❑ None
- ❑ Sunglasses
- ❑ Single
- ❑ Bifocal
- ❑ Trifocal
- ❑ Lenticular
- ❑ Contacts
- ❑ Other _____

DATE: ORDER / DELIVERY

CONTACT LENSES
- ❑ Therapeutic
- ❑ Non-therapeutic
- ❑ Permanent lenses
- ❑ Disposable lenses

FRAME MODEL OR CAT NO.

FRAME MFG. NAME

I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON

_____
DISPENSER'S SIGNATURE DATE

PROFESSIONAL SERVICES		AMOUNT
Lens charge		
Frame charge		
LENS	Materials	
LENS	Dispenser Fee	
FRAMES	Materials	
FRAMES	Dispenser Fee	
Sales tax (if any)		
TOTAL		

Scan and submit claim and attachments at emihealth.com/web/claim.aspx