

Please submit to:
 Activa Benefit Services, LLC.
 2905 Lucerne Dr., S.E., Suite 555
 Grand Rapids, MI 49546
 Claims: 866-807-1097
 Fax: 616-787-4590

VISION CLAIM

Patient & Employee Information

1. Patient Name	2. Patient Date of Birth	3. Employee Name
4. Employee's Address	5. Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Employee Social Security Number
	7. Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	8. Employee's Company Name
9. Othe Vision Insurance Coverage - Enter Name and Policy Number.	10. Condition Related to Patient's employment Auto Accident If yes, please provide explanation.	
11. Patient's or Authorized Person's Signature. I Authorize the Release of any Vision Information Necessary to Process this claim. Signed _____ Date _____		12. 1 Authorize Payment of Vision Plan Benefits to Undersigned Provider for Services Described below. Signed _____ Date _____

Pay Me (Sign Box 11 Only)

Pay Provider (Sign Box 11 & 12)

Provider Information		Charges		
Exam Date of Service _____		\$ _____		
Lenses: Date of Service _____		\$ _____		
Type of Lense(s). <input type="checkbox"/> Single <input type="checkbox"/> Tinted <input type="checkbox"/> Bifocal <input type="checkbox"/> Sunglasses <input type="checkbox"/> Trifocal <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Cther _____				
Frames: Date of Service _____		\$ _____		
Contacts: Date of Service _____		\$ _____		
Please state reason for contacts (severe corneal astigmatism, severe corneal scarring, aphakia, or patient prefers contacts, etc.) _____				
	Total	\$ _____		
	Paid	\$ _____		
	Balance Due	\$ _____		
Date	Provider Name	Signature	License #	SSN or Tax ID
Street Address	City	State	Zip Code	Telephone