



Please submit to:
Activa Benefit Services, LLC.

2905 Lucerne Dr., S.E.
 Grand Rapids, MI 49546
 Claims: 866-807-1097
 Fax: 616-588-5341

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. Other Vision Insurance Coverage -- Enter Name and Policy Number.	10. Condition Related to: <input type="checkbox"/> Patient's employment <input type="checkbox"/> 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. I 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):

- Single Tinted
 Bifocal Sunglasses
 Trifocal Safety Glasses
 Other _____

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