Please submit to:

Activa Benefit Services, LLC.

P.O.BOX 37
Farmington, MI 48332-0037
Claims: (877) 827-1414 or (616) 588-5340
Fax: (616) 588-7915 Email: RA-TPA@activabenefits.com

Vision Claim

Patient & Employee Information

1. Patient Name	2. Patient Date of Birth	3. Employee Name
4. Employee's Address	5. Patient's Sex ☐ Male ☐ Female	6. Employee Social Security Number
	7. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	8. Employee's Company Name
9. Other 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. 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 Lens:
☐ 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