MUTUAL HEALTH SERVICES℠

P.O. Box 5700 ♦ Cleveland, Ohio 44101
800-367-3762 ♦ Fax (330) 666-6685

STATEMENT OF CLAIM FOR VISION CARE

NOTE: COMPLETE THE SECTION BELOW. IF YOU ARE REQUESTING REIMBURSEMENT, OBTAIN FROM THE DOCTOR ITEMIZED BILLS SHOWING THE NAME OF THE PATIENT, DATE OF SERVICE, THE CHARGES AND EXACTLY WHAT THE CHARGES WERE FOR. SUBMIT THIS FORM AND THE BILL TO THE ABOVE ADDRESS. REIMBURSEMENT WILL BE ACCORDING TO YOUR PLAN SCHEDULE OF BENEFITS. IF YOU WANT PAYMENT MADE DIRECTLY TO THE DOCTOR, PLEASE HAVE THE BOTTOM OF THIS FORM COMPLETED BY THE PROVIDER.

TO BE COMPLETED BY EMPLOYEE

1. _____ PRINT FULL NAME
2. _____ HOME ADDRESS
3. _____ CITY STATE ZIP CODE
4. _____ GROUP NUMBER

COMPLETE ONLY IF A DEPENDENT CLAIM

_____ FULL NAME OF DEPENDENT

_____ BIRTH DATE

_____ RELATIONSHIP TO PATIENT

_____ EMPLOYEE SOC. SEC. NUMBER

5. Were any of the expenses covered by Workers' Compensation? ☐ YES ☐ NO
6. Is the person for whom claim is being made covered under any other vision care plan? ☐ Yes ☐ No
   If Yes, name and address of other company: _____

The above answers are true to the best of my knowledge. I hereby authorize any doctor or optician, any insurance company or other organization to release any information required, including benefits paid or payable.

_____ DATE

_____ EMPLOYEE'S SIGNATURE

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE FOR DIRECT PAYMENT OF BENEFITS TO THE OPTOMETRIST OR OPTHALMOLOGIST. (*This assignment may be honored if signed by a dependent or person other than the employee.*)

DATED: _____ SIGNED: _____

TO BE COMPLETED BY EXAMINING DOCTOR (*Optometrist or Opthalmologist*)

1. _____ NAME OF PATIENT EXAMINED _____ DATE OF EXAMINATION
2. CHARGE OF EXAM $ _____ TONOMETRY YES _____ NO _____
3. DOCTOR'S NAME _____ PLEASE PRINT _____ DOCTOR'S SIGNATURE

   ADDRESS _____

   TELEPHONE _____

TO BE COMPLETED BY SUPPLIER OF LENSES AND/OR FRAMES (*Optometrist or Optician*)

1. _____ NAME OF PERSON FOR WHOM GLASSES WERE FURNISHED _____ DATE GLASSES PROVIDED
2. CHARGE FOR LENSES

Single Vision L ☐ R ☐	Trifocal L ☐ R ☐	Lenticular L ☐ R ☐
Bifocal L ☐ R ☐	Contacts L ☐ R ☐	

Materials: L $ R $	Extras: L $ R $	Tax: L$ R$

3. CHARGE FOR FRAMES:
   Material: $ _____ Extras: $ _____ TAX: $ _____
   INDIVIDUAL PRACTIONERS: SS Number: _____ - _____ - _____
   ALL OTHERS: Employer ID Number: _____ - _____
4. OPTICIAN AGENCY NAME: _____ SIGNATURE: _____