

EYE CARE GROUP CLAIM FORM

Group Claim Office / P.O. Box 82510, Lincoln, NE 68501
Toll Free No.: 800-497-7044 / Fax: 402-467-7336

RELIANCE STANDARD
Life Insurance Company

a DELPHI company

PLEASE BE AS COMPLETE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM.
ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

PART A - TO BE COMPLETED BY INSURED

1. PATIENT'S NAME (Last, First, Middle)		2. PATIENT'S BIRTHDATE	3. PATIENT'S SEX <input type="checkbox"/> M <input type="checkbox"/> F	4. RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
5. INSURED'S NAME (Last, First, Middle)		6. INSURED'S SOCIAL SECURITY NO.	7. INSURED'S BIRTHDATE	
8. INSURED'S STREET ADDRESS		9. NAME OF EMPLOYER / GROUP NUMBER		
10. CITY, STATE, ZIP CODE				

11. IS PATIENT COVERED FOR EYE CARE BY ANOTHER PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please complete boxes 12 through 16.		12. NAME AND ADDRESS OF OTHER CARRIER		
13. INSURED'S NAME	14. RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	15. INSURED'S BIRTHDATE	16. INSURED'S SSN / GROUP NUMBER	

17. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER.

Is patient a full-time student? Yes No. If YES, Name and Address of School _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO RELIANCE STANDARD ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.

SIGNATURE OF INSURED _____ DATE _____

It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and/or civil penalties can result from such acts.

PART B - TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME (Last, First, Middle)			2. TITLE <input type="checkbox"/> D.O. <input type="checkbox"/> M.D. <input type="checkbox"/> O.D.		
3. DOCTOR'S STREET ADDRESS			4. CITY, STATE, ZIP CODE		
5. PHONE ()	6. WERE EYEGLASSES PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE CONTACTS PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO	7. HAS CATARACT SURGERY BEEN PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	8. EXAMINATION DATE PLEASE ENTER EXAMINATION CHARGE IN FEE COLUMN BELOW (BLOCK 12.)		
9. ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Doctor's Tax I.D. # _____		10. I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON. DOCTOR'S SIGNATURE _____ DATE _____			

11. DIAGNOSIS OR NATURE OF OFFICE VISIT	12. EXAMINATION CHARGE	AMOUNT

PART C - TO BE COMPLETED BY DOCTOR/DISPENSER

CHECK APPROPRIATE BOX

FRAME	SIZE & MODEL				MFG.				ZYL	METAL	RIMLESS	COMBO	12. EXAMINATION CHARGE	AMOUNT
LENSES	# OF LENSES	GLASS	PLASTIC	SV	BIF	TRI	PAL	SAFETY	OTHER				FRAME CHARGE	
LENS OPTIONS	OS	TINT	GRAD	DBL GRAD	COAT	UV400	FACET	PHOTO CHROMIC	OTHER				LENS CHARGE	
CONTACT LENSES	# OF LENSES	HCL	SCL	HGP	DISPOS-ABLE	SPH	BIF	TORIC	EW	TINT	NUMBER REPLACED	OTHER	OPTIONS CHARGE	
DATE ORDERED	DATE DISPENSED				OTHER SERVICES								CONTACT CHARGE	
DISPENSING OFFICE										PHONE ()			OTHER SERVICES	
ADDRESS		STREET			CITY			STATE		ZIP			SUBTOTAL	
ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Dispensers Tax I.D. Number _____													SALES TAX (If Applicable)	
I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.													TOTAL CHARGES	
DISPENSER'S SIGNATURE _____ DATE _____													AMOUNT PAID BY PATIENT	