



**Planned Administrators
Incorporated**

Claims Processing Unit
P.O. Box 6927
Columbia, SC 29260

VISION CLAIM FORM

FOR OFFICE USE ONLY

Before completing this form, see reverse for instructions. Use a separate claim form for each patient.

1. Member's Identification Number		2. Member's Name		First	M.	Last	
3. Home Telephone Number Area Code	4. <input type="checkbox"/> Check if new address	5. Member's Address		Street	Apt. No.	City	State Zip Code
7. Patient's Name		First	M.	Last		8. Patient's Birthdate	
				Mo.	Day	Yr.	9. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
10. Relationship to Member							

11. Diagnosis or condition requiring treatment.

12. Was any treatment required as the result of accidental injury? Yes No
Was another person at fault? Yes No If yes, please attach a statement explaining details of accident to this form.

13. Was any injury or illness work-related? Yes No If yes, was a Workers Compensation Claim filed? Yes No

14. Is the patient covered by Medicare Health Insurance, Part A? Yes No Or by Supplemental Medical Insurance, Part B? Yes No
If yes, please complete the following: Part A: HIB Number _____ Part B: HIB Number _____

15. Is the patient covered under any other group health insurance plan (including, but not limited to, CHAMPUS or Federal Employee Program (FEP)?
 Yes No If yes, please complete the following:

a. Name and address of Other Insurance Company: _____

b. Name of Policyholder: _____ Relationship to Patient: _____
Policy Number: _____ Effective Date: _____
Name and Address of Employer: _____

Provider should complete shaded areas – Otherwise, member must attach itemized bills.

16. Procedure Code	Exam	Procedure Code	Frames
M934E	Visual acuity, Ophthalmoscopy, Tonometry, gross visual fields muscle balance and slit lamp microscopy.	G0086	Pair
M934F	With refraction		<u>Lenses</u> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Pair
M934G	With plotting central and/or peripheral visual fields.	G0054	Single
M934H	With refraction and plotting of central and/or peripheral visual fields.	G0056	Bifocal
M934I	With refraction, Keratometry and diagnostic services for contact lenses.	G0032	Aphakic (plastic)
		G008C	Contact

17. To be completed if contacts are medically required. Surgery Date: _____
 Other necessity – visual acuity in better eye corrected to: _____ with glasses _____ with contacts.

18.

Line	Date of Service	Procedure Code (from above)	Provider Number	Diagnosis	Med. Nec.	Charge	EOB
1							
2							
3							
4							
Total Lines		Total Charge		PE	MSG	AUTH	

19. Provider Name _____
Street Address _____
City and State _____

Signature of Provider
I hereby certify that the procedures as indicated above have been completed by me or under my direct supervision.
Date _____ Provider's Signature _____
(Not required if filed by member.)

20. CERTIFICATION OF MEMBER

I certify that the above information is correct and that I am claiming benefits only for the charges incurred by the patient named above. Authorization is hereby given to any provider, which participated in any way in my care and treatment, to release to Planned Administrators, Inc. any medical information that they, in their judgment, deem necessary to the adjudication of this claim.

Date _____ Member's Signature _____
(Not required if filed by member.)

CONTRACTUAL NOTES

Benefits are provided for the following medically necessary services or supplies performed or prescribed by a physician.

1. Routine eye examinations, limited to one a year, unless medical documentation warrants otherwise.
2. Lenses, as follows, limited to one pair per member per contract year:
 - a. Single Vision
 - b. Bifocals
 - c. Trifocals
 - d. Aphakic:
 - (1) glass
 - (2) plastic
 - (3) aspheric
 - e. Lenticular
 - f. Contacts, hard or soft, only following cataract surgery or when visual acuity is not otherwise correctable to at least 20//70 in the better eye.
3. Frames, limited to one set per member in a 24-month period.

FILING TIPS

If entire claim is completed by the member, an itemized bill from the provider must accompany the claim form.

MAKE SURE EVERY ITEMIZED BILL SHOWS THE FOLLOWING:

- * Name and Address of provider or supplier rendering services.
- * Type of each service or supply.
- * Date each service or supply was received.
- * Amount charged for each service or supply.
- * Patient's name.

Mail completed claim form and itemized bills (if necessary) to:

**Planned Administrators, Inc.
Claims Processing Unit
P.O. Box 6927
Columbia, SC 29260**

SPECIFIC INSTRUCTIONS FOR COMPLETING ITEMS 1 THROUGH 20 ON THIS FORM (* indicates provider completion)

1. Member's Identification Number: Number appearing on Identification Card.
2. Member's Name: Name appearing on Identification Card.
3. Home Telephone Number: Area code and number.
4. Check this block if address is new and you want our records corrected.
5. Member's Address: Complete mailing address.
6. Employer's Name and Address: Do not complete if you hold an individual contract.
7. Patient's Name: Patient's first, middle initial, and last name. Please do not use nickname. Always use the same name when filing, e.g., Mary J. always file as Mary J.
8. Patient's birthdate: Patient's month, day, and year of birth.
9. Patient's Sex: Check appropriate box.
10. Patient's Relationship to Member: Check appropriate box. If "Other," please specify such as "foster child," "student," etc.
11. Diagnosis: Indicate condition for which all treatment was rendered in this section, or indicate by charge on itemized statement for what condition treatment was given.
12. Accidental Injury: Check appropriate box. Give date of accident. If another person was at fault, attach a statement explaining details of the accident.
13. Work-related: Check appropriate box.
14. Medicare Healthcare Benefits: If the patient is covered by Medicare Health Insurance, Part A or Supplemental Medical Insurance, Part B, please complete this section.
15. Other Health Insurance Coverage: If patient is covered under any other group health insurance plan, this section should be completed in as much detail as possible. If any benefits have been paid by the other insurance, please attach a copy of their Notice of Payment.
- *16. To be completed by the provider.
- *17. To be completed by the provider.
- *18. To be completed by the provider using procedure codes indicated in Item 16.
- *19. Signature – Complete name and address of provider and obtain provider's signature.
20. Signature – Signature of patient (unless minor) and member.