Vision Claim Form

Meritain Health®
an aetna company

Complete and send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057

For ALL claims, this area must be filled in completely.

Employee Information

Employee's Name (last, first, middle initial)			Employee ID Number
Address			Employee's Date of Birth
City	State	Zip Code	☐ Single ☐ Married ☐ Widowed ☐ Divorced

If the patient is a dependent, please complete ALL of the following. If the patient is the employee, go directly to the area below the shaded box.

Patient Information

Patient's Name (if other than employee)	Patient's ID Number	
Patient's Date of Birth (Month, Day, Year)	Relationship to Employee ☐ Spouse ☐ Child	If child, is (s)he married? ☐ Yes ☐ No

Is patient covered by another Employer Group Plan or Retirement Group Plan?
☐ Yes ☐ No (If yes, please complete the two items below)

Name of Employer	Group Number	Name and address of Insurance Company or Organization

Release

Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud, submits an application for coverages, or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Criminal and/or Civil penalties can result from such acts.

I hereby authorize payment of these benefits be send directly to:
☐ Provider of Service ☐ Employee **(attach itemized bill or receipt)**

Patient's Signature (parent or guardian if claim is on a minor)	Date

The below sections are to be completed by the Provider.

Exam

Indicate the nature of disease, injury or vision disorder	Date of examination	Name of provider performing services
Refraction? Yes ☐ ☐ No Contact Lenses? Yes ☐ ☐ No Tonometry? Yes ☐ ☐ No Cataract Surgery? Yes ☐ ☐ No		Address
Examination Charge: $		City
Amount paid by employee: $		State / Zip Code
Signature of provider / Degree/Title	Date	Provider's Social Security or Tax ID Number (required by law):

Lenses

Date ordered:	Date dispensed:	☐ Pair ☐ 1/2 Pair

	Sphere	Cylinder	Axis	Prism	Add
OD					
OS					

Type Lens:	**Charge**
☐ Single vision ☐ Bifocal ☐ Trifocal ☐ Lenticular	
☐ Contact Lenses	
☐ Oversized Lenses	
☐ Sunglasses	
☐ Tint #	
☐ Photosensitive – i.e. Brown, Gray, etc.	
☐ Other	
Lens Manufacturer:	
Lens Charge	**$**

Frames

Date ordered	Date dispensed	Parts ☐ Complete ☐ Partial
	Frame Charge	**$**

Name of provider performing services (please print)

Address	City, State, Zip

Provider's Social Security Number or Tax ID Number

Signature of provider	Degree/Title	Date

Total Charge:	**$**	**Amount paid by employee:**	**$**

IMPORTANT: CLAIMS CANNOT BE PAID UNTIL THE CLAIM FORM IS PROPERLY COMPLETED AND RECEIVED. Do not send this form through your employer. ATTACH PROVIDER BILLING. If you require assistance in presenting this claim, call your Service Delivery Team at the number listed on your member ID Card.