eye care
group claim form

Group Claim Office / P.O. Box 82520 / Lincoln, NE 68501-2520
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AMERITAS LIFE INSURANCE CORP.

PART 1 – TO BE COMPLETED BY EMPLOYEE

1. Patient's full name (first, middle initial, last)	2. Patient birthdate (MM/DD/YY)	3. Relationship to employee	4. Sex
		☐ self ☐ spouse ☐ child ☐ other	☐ M ☐ F

5. Employee's full name (first, middle initial, last)	6. Employee's identification number	Employee's birthdate (MM/DD/YY)

7. Employee's mailing address (Street address or P.O. Box, City, State, ZIP) Email address	8. 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

9. Employer (company) name and address	10. Group number	Division number	Certificate number

QUESTIONS 11 AND 12 MUST BE COMPLETED WITH **EACH** CLAIM SUBMISSION

11. Is patient covered by another eye care plan? ☐ Yes ☐ No	Name and address of other carrier	Policy number	Name and address of other employer

12. Other employee/subscriber name	Employee/subscriber identification number	Date of birth (MM/DD/YY)	Relationship to patient

13. **I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of treatment. I certify these statements to be true and complete to the best of my knowledge.**

X _____ _____
Signature (patient, or parent if minor) Date

14. **I hereby authorize payment directly to the below named provider of group insurance benefits otherwise payable to me.**

X _____ _____
Signature (insured person) Date

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

PART 2 – TO BE COMPLETED BY ATTENDING EYE CARE PROVIDER.

15. Eye care provider name and mailing address		**For Yes answers to questions 17-19, enter a brief description and date.**
		17. Is treatment result of occupational illness or injury? ☐ Yes ☐ No
		18. Is treatment result of auto accident? ☐ Yes ☐ No
Specialty	Phone number	19. Other accident? ☐ Yes ☐ No
Email	Fax number	20. This is a (please check one): ☐ Statement of actual services ☐ Pretreatment estimate
16. Federal tax ID number ☐ SSN ☐ TIN	NPI (National Provider Identifier)	21. Is this for LASIK/PRK? ☐ Yes ☐ No
License #		

22. EXAMINATION AND TREATMENT RECORD Please include date of service, description of services, procedure code and fee.

Date service performed (MM/DD/YY)	Description of services	CPT/HCPCS procedure code	Diagnosis code	LASIK PRK	Left eye	Right eye	Fee

23. Remarks

24. Total
$

25. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.

X _____ _____
Signature (Provider) Date

26. Address where treatment was performed

tips

how to speed claims processing

part 1 – employee

Missing or incomplete information will slow down claims processing. To avoid this, please be sure to include:

#2 Patient birthdate
Helps identify an insured and determine dependent eligibility.

#6 Employee's identification number
This is the most important identifier for the plan member.

#8 Student status
Because this information often changes, it is required on every claim for dependents age 19 years and older.

#11 and **#12** Coordination of benefits
The No box under #11 should be checked if no other **eye care** coverage exists. If there is other eye care coverage, the additional information requested is necessary for coordination of benefits.

#21 and **#22** LASIK/PRK
If LASIK or PRK, please make sure your eye care provider marks the Yes box under #21, and includes description of services, procedure code, which eye (left, right or both), and the fee for each eye in the Examination and Treatment Record.

part 2 – eye care provider

To help expedite the claims process, please be sure to include:

#16 National Provider Identifier
There are two types of NPI. Type 1 is for individual providers who operate independently. Type 2 is for health care providers such as group practices or corporations. Type 2 organization providers may want their individual provider employees to have Type 1 NPIs to distinguish them individually.

#20 Statement of actual services, or Pretreatment estimate
Appropriate box should be marked to ensure correct handling.

NOTE: If there are two different providers (one for the exam, another for eyewear), we request that each provider submit a separate claim form.

abbreviations	
VE	vision exam
FR	frame
SV	single vision lenses
BI	bifocal lenses
TR	trifocal lenses
LE	lenticular lenses
PP	progressive lenses
CD	contacts
CN	necessary contacts
CC	cosmetic contacts

pretreatment estimate of benefits

We recommend a pretreatment estimate of benefits when a plan member considers the services to be expensive. A pretreatment estimate lets both the member and eye care provider know in advance how much insurance will pay. If eye care coverage terminates for any reason during treatment, only procedures performed before coverage ended will be eligible for payment.

For full information regarding coverage, plan members may refer to their insurance plan booklet.

website

Visit our website for benefit information, electronic forms, a list of eye care providers if your plan includes a network, and more. Please note, the free software Adobe Reader® (available through the internet) is needed to view and print the electronic forms.