VISION CLAIM NOTICE

ADMINISTERED BY:

HealthSmart™
HEALTHCARE SOLUTIONS

ENROLLEE: TO AVOID DELAYS, PLEASE FOLLOW THE INSTRUCTIONS BELOW.

1. SUBMIT A SEPARATE FORM FOR EACH FAMILY MEMBER.
2. INDICATE PLAN SPONSOR'S NAME, YOUR NAME AND YOUR SOCIAL SECURITY NUMBER ON ALL CORRESPONDENCE.
3. ATTACH ALL RECEIPTS FOR VISION CHARGES TO BE CONSIDERED FOR REIMBURSEMENT.
4. RETURN COMPLETED FORM TO THE MAILING ADDRESS INDICATED ON YOUR I.D. CARD.

I. GROUP INFORMATION

GROUP NAME:	GROUP NUMBER:
JEFFERSON LOCAL SCHOOLS	735

II. ENROLLEE/PATIENT INFORMATION: COMPLETE FOR ALL CLAIMS

1. PATIENT NAME:	2. RELATIONSHIP TO ENROLLEE: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	3. SEX: ☐M ☐F	4. PATIENT DATE OF BIRTH: / /	5. IF FULL-TIME STUDENT: SCHOOL: CITY:
6. ENROLLEE NAME: FIRST MIDDLE LAST		7. ENROLLEE SOCIAL SECURITY NUMBER:		8. ENROLLEE DATE OF BIRTH: / /
9. HOME ADDRESS: STREET CITY STATE ZIP				
10. ARE YOU STILL ENROLLED IN PLAN? ☐ YES ☐ NO	11. IF NO, DATE OF TERMINATION: / /	12. DATE YOU BECAME RETIRED: / /	13. COBRA COVERAGE EFFECTIVE DATE: / /	
14. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO	15. IF YES, EMPLOYEE NAME AND SOCIAL SECURITY NUMBER:			
16. NAME AND ADDRESS OF EMPLOYER IN BOX #15: STREET CITY STATE ZIP				
17. IS PATIENT COVERED BY ANOTHER PLAN? ☐ YES ☐ NO	18. IF YES, VISION PLAN NAME: GROUP NO. NAME/ADDRESS OF CARRIER:			
19. IS CLAIM DUE TO: ☐ ILLNESS ☐ ACCIDENT (GIVE DESCRIPTION)			20. IS INJURY/ILLNESS RESULT OF EMPLOYMENT? ☐ YES ☐ NO	
IF ACCIDENT, COMPLETE THE FOLLOWING:	21. DATE AND TIME OF ACCIDENT:		22. LOCATION OF ACCIDENT:	
23. CAUSE(S) OF ACCIDENT:				
24. WAS ILLNESS/INJURY CAUSED BY NEGLIGENCE OF THIRD-PARTY? (i.e., BUSINESS ESTABLISHMENT, FAULTY PRODUCT, AUTO ACCIDENT) ☐ YES ☐ NO			25. IF AUTO ACCIDENT, IS NO-FAULT INSURANCE APPLICABLE? ☐ YES ☐ NO	

III. MANDATORY AUTHORIZATION SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE ANY PROVIDERS OF HEALTHCARE SERVICES, SUPPLIERS, CLAIM ADMINISTRATORS, INSURERS, REINSURERS AND OTHERS WHO HAVE A LEGITIMATE NEED FOR SUCH INFORMATION FOR THE PURPOSE OF REVIEW, INVESTIGATION OR EVALUATION OF A CLAIM TO SUPPLY EACH OTHER WITH THE INFORMATION ABOUT MY HEALTH STATUS AND HEALTHCARE SERVICES PROVIDED TO ME. I FURTHER AGREE TO REIMBURSE THE PLAN TO THE EXTENT OF ANY PAYMENT WHICH IS IN EXCESS OF THE AMOUNT PAYABLE UNDER THIS PLAN. I AGREE THAT A PHOTOCOPY OF THE AUTHORIZATION IS AS VALID AS THE ORIGINAL.

ENROLLEE'S SIGNATURE	**DATE**
SPOUSE'S SIGNATURE (FOR SPOUSE OR CHILD'S CLAIM)	**DATE**

(REV. 2/11)