

THE MANHATTAN LIFE INSURANCE COMPANY

Claim Form

CAUTION: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

PART A TO BE COMPLETED BY PATIENT (INSURED) IMPORTANT: ALL QUESTIONS MUST BE COMPLETED AND FORM SIGNED

Insured's Name		Social Security No.	
Street Address	City or Town	State	Zip Code
Office Phone No.	Date of Birth	Marital Status	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>

IF A DEPENDENT CLAIM

Dependent's Name	Date of Birth	Relationship
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Are you entitled to an income tax exemption for this dependent? Yes No

If child, is he/she employed? Yes No Name of employer _____

Sex: Male Female If child is over 19 years old, is child a full-time student? Yes No

Name of school _____

Are you or your dependent entitled to benefits under: Any other vision plan? Yes No Medicare Yes No

If yes, name of family member holding policy _____ Policy No. _____

Name and address of employer, union, association, school, etc., carrying other plan

Name and address of other insurance company

PLEASE SIGN AND DATE AUTHORIZATION

I accept this claim form and authorize release of information relating hereto. I certify the truth of all personal information contained above and that all the services listed above have been completed/delivered. I agree to be responsible for the applicable co-payment as detailed in my Group program, for any services indicated as rendered. I also agree to be responsible for any and all services which may be rendered but not eligible for coverage under my Group Program.

Patient (Parent or Subscriber Signature) _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of the Vision Benefits for the services as described on this claim but not to exceed the scheduled amount of covered vision care expenses for these services.

Insured Person (Signature) _____ Date _____

TO BE COMPLETED BY THE MANHATTAN LIFE INSURANCE COMPANY

Eligibility and status approved by The Manhattan Life Insurance Company

Claims Administrator _____ Date _____

V-10/97

The Manhattan Life Insurance Company
P.O. Box 925309
Houston, TX 77292-5309

**COMPLETE AND RETURN
THIS FORM PROMPTLY**
Please fold in half, then fold in half again
so that the address is showing thru the
window in the enclosed envelope

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PART B TO BE COMPLETED BY PROVIDER

Name _____ Mailing Address _____ City, State, Zip _____

Soc. Sec. No. or E.I.N. _____ License No. _____ Phone No. _____

1. Is exam required as condition of employment? Yes No 2. Is exam the result of occupational injury? Yes No
 3. Is exam the result of auto accident? Yes No 4. Other accident? Yes No

If Yes to 1, 2, 3 or above, give brief description and dates _____

EXAMINATION	Description	Date	Code	Fee	Plan Allowance	Patient Responsibility

HAVE GLASSES BEEN PRESCRIBED? Yes No

Description: <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal	Date	Code	Fee	Plan Allowance	Patient Responsibility
Bifocal/Trifocal Style: _____					

Prescription:

	Sphere	Cylinder	Axis	Prism	Base	Base Curve
R						
L						

	BIFOCAL ADD	Height	Width	PUPILLARY WIDTH:	Reading	Distance
R						
L						

FRAMES: Mfg. Name & Style: _____

HAVE CONTACT LENSES BEEN PRESCRIBED? Yes No

Description: <input type="checkbox"/> Hard <input type="checkbox"/> Soft <input type="checkbox"/> Gas Permeable	Date	Code	Fee	Plan Allowance	Patient Responsibility
<input type="checkbox"/> Extended Wear <input type="checkbox"/> Bifocal					

Prescription:

Hard or Soft Daily Wear Contact Lenses

	Base Curves	Lens Rx	Lens Size	2nd Curve Width	P.C. Width	2nd. Curve Radius	P.C. Radius	O.Z.	Tint
R									
L									

Gas Permeable or Extended Wear Contact Lenses

	Lens Rx	Lens Size	Type or Mfg.	Add	Seg. Hgt.
R					
L					

BIFOCAL CCL.

Bifocal Style

RAM

- Crescent
- Curve Top
- One Piece

Manufacturer & Style #: _____

The services listed above are the only services considered for possible benefits under your vision care plan. Payment of these services is subject to current eligibility on the date services are completed/delivered.

I hereby certify that the services as indicated by the date listed have been completed/delivered and that the fees submitted are the actual fees charges and intended to be collected for these services. Payment is requested in accordance with the rules and regulations of The Health Application Network

Provider Signature _____ Date _____

PROVIDER signature Required