National Vision Administrators, L.L.C.

OUT OF NETWORK VISION CARE CLAIM FORM INSTRUCTIONS

- Use this form to obtain reimbursements for services
- Complete Part A of this form
- Include a copy of your receipts with your completed vision care claim form

WAYS TO SUBMIT:

- Scan and submit form by e-mail to: visionclaims@e-nva.com
- Submit the form by fax to: (973) 574-2430
- Submit the form by mail to: National Vision Administrators, L.L.C.
  P.O. Box 2187
  Clifton, New Jersey, 07015

If you have any questions, please contact NVA at (800) 672-7723.

National Vision Administrators, L.L.C.

VISION CARE CLAIM FORM

NATIONAL VISION ADMINISTRATORS, L.L.C.
P.O. BOX 2187 / CLIFTON, NJ 07015
800-672-7723

PLEASE PRINT INFORMATION

PART A: TO BE COMPLETED BY EMPLOYEE

1. EMPLOYEE'S NAME (LAST, FIRST, MIDDLE)	2. EMPLOYEE'S ADDRESS (No., Street, City, State, Zip Code)
3. EMPLOYER'S IDENTIFICATION # Group 8506	4. EMPLOYEE'S TELEPHONE #
5. EMPLOYER'S NAME Georgia Ports Authority	6. EMPLOYER'S ADDRESS (No., Street, City, State, Zip Code) P.O. Box 2406, Savannah, GA 31402

7. PATIENT'S NAME (LAST, FIRST, MIDDLE)	8. PATIENT'S RELATIONSHIP TO EMPLOYEE □ SELF □ CHILD □ STUDENT □ SPOUSE □ HANDICAPPED □ OTHER _____	9. PATIENT'S GENDER □ MALE □ FEMALE	10. PATIENT'S DATE OF BIRTH

11. IS PATIENT COVERED BY ANOTHER VISION PLAN? □ YES □ NO	VISION PLAN NAME	GROUP #	NAME AND ADDRESS OF CARRIER

12. Anyone who knowingly and with intent to defraud any insurance company or other person; files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties.

PART B: TO BE COMPLETED BY EYE CARE PROFESSIONAL (OPTIONAL)

1. DOCTOR'S NAME (LAST, FIRST, MIDDLE)	2. TAX PAYER IDENTIFICATION #	3. BUSINESS PHONE # (area code)
4. TITLE: □ MD □ DO □ OD	5. DOCTOR'S ADDRESS (No., Street, City, State, Zip Code)	

6. PROFESSIONAL SERVICE	7. AMOUNT	8. EXAMINATION DATE	9. WAS CATARACT SURGERY PERFORMED? □ YES □NO
EYE EXAMINATION	$	10. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTION EYEGLASSES?	□ YES □NO
CONTACT LENS EXAM (if any)	$	11. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME?	□ YES □NO
AMOUNT PAID BY PATIENT	$	12. DIAGNOSTIC CODE(s)	

13. INDICATE DIAGNOSIS OR NATURE OF DISEASE, INJURY, VISION DISORDER. CODE #'S INDICATE PROCEDURE	14. VISUAL ACUITY CORRECTED TO:

15. Doctor's Prescription						16. I hereby certify that I have performed the services as indicated heron.
SPHERE		CYLINDER	AXIS	PRISM	BASE	
R.E.		●				
L.E.		●				
READING ADD		R.E.	+ ●	L.E.	+ ●	DOCTOR'S SIGNATURE DATE

PART C: TO BE COMPLETED BY DISPENSER

1. DISPENSER'S NAME (LAST, FIRST, MIDDLE)	2. TAX PAYER IDENTIFICATION #
3. DISPENSER'S ADDRESS (No., Street, City, State, Zip Code)	4. BUSINESS PHONE # (area code)

5. PROFESSIONAL SERVICES

DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPC	MODIFIER		DIAGNOSIS CODE	$ CHARGES		DAYS OR UNITS

6. PATIENT'S ACCOUNT #	7. TOTAL CHARGED $	8. AMOUNT PAID $	9. BALANCE DUE $

10. I hereby certify that I have performed the services as indicated hereon.

DISPENSER'S SIGNATURE DATE

Scan and submit via e-mail: visionclaims@e-nva.com or submit via fax at 973-574-2430