

MAIL TO: CEBT/CNIC  
 P.O. Box 76149  
 Colorado Springs, CO 80970-6149

# VISION CARE CLAIM FORM CEBT

Group: CEBT

**Employee's Statement** *(see instructions on other side)*

**EMPLOYEE INFORMATION:**

NAME (Last)	(First)	(Middle)	SOCIAL SECURITY NUMBER / /
ADDRESS (Street)	(City)	(Zip Code)	OCCUPATION:
DATE OF BIRTH (month, day, year) / /	SEX <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW(ER)

**DEPENDENT INFORMATION: COMPLETE ONLY IF PATIENT IS A DEPENDENT**

DEPENDENT'S NAME	DATE OF BIRTH (mo day yr)	RELATIONSHIP <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER	IS CHILD-PATIENT EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> PART-TIME <input type="checkbox"/> NO <input type="checkbox"/> FULL-TIME
SEX <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOW(ER)	<input type="checkbox"/> LEGALLY SEPARATED	IS CHILD-PATIENT OVER AGE 19 FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF 'YES', GIVE NAME & ADDRESS OF SCHOOL.

**OTHER COVERAGE INFORMATION: COMPLETE IN ALL CASES**

IS PATIENT COVERED BY ANY OTHER GROUP PLAN WHICH PROVIDES VISION CARE BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF 'YES', BY WHOM: (EMPLOYEE NAME, EMPLOYER NAME & ADDRESS & POLICY NO.)
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**All the above statements are true and complete to the best of my knowledge.**

EMPLOYEE'S SIGNATURE <b>X</b> _____ <small>(signature necessary on all claims)</small>	DATE SIGNED _____ 19____ <small>month day yr</small>
SIGNATURE OF PATIENT <b>X</b> _____ <small>(required only if patient is spouse)</small>	DATE SIGNED _____ 19____ <small>month day yr</small>

**EXAMINING PHYSICIAN OR OPTOMETRIST'S INFORMATION**

Indicate Diagnosis or Nature of Disease, injury or Vision Disorder	Type of vision care patient had prior to this examination <input type="checkbox"/> Conventional Lenses <input type="checkbox"/> Contacts <input type="checkbox"/> Low Vision Aids <input type="checkbox"/> Visual Training/Vision Therapy <input type="checkbox"/> Medication State condition treated _____ <i>Surgery (explain) _____</i>
Describe conditions diagnoses which require treatment at this time	Does Patient require a prescription change at this time? Frames <input type="checkbox"/> YES <input type="checkbox"/> NO Lenses <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, why? _____
Indicate date of patient's last change of: lenses _____ frames _____ Check the materials or treatment prescribed (note number prescribed): <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Contact lens <input type="checkbox"/> Frames _____ <input type="checkbox"/> Low Vision aid <input type="checkbox"/> Visual Training/vision therapy <input type="checkbox"/> Other _____	If Contact Lenses, would the visual acuity be corrected to 20/70 in the better eye by use of Conventional Lenses? <input type="checkbox"/> YES <input type="checkbox"/> NO

If tinted lenses, photograys, sunglasses or conventional lenses are prescribed which are not impact-resistant, state reason why: \_\_\_\_\_

Report of services, or attach itemized bill. (If previous form submitted to this carrier, you need show only dates and services since last report)

Date of Service	Services Rendered	Charges	

Physician's or Optometrist's Name, Address, Zip Code, and Telephone No	Social Security No.	Total Charges	
	Employer I D. No.	Amount Paid	
	Other identifying No.	Balance Due	
Accept Assignment <input type="checkbox"/> YES <input type="checkbox"/> NO	Signature of Physician/Optometrist Sign Here	Date Signed	Your Patient's Account No

**AUTHORIZATION FOR DIRECT PAYMENT: COMPLETE ONLY IF YOU WISH PAYMENT TO BE MADE DIRECTLY TO PHYSICIAN OR OPTOMETRIST**

I authorize payment of medical benefits for services rendered by (specify) \_\_\_\_\_

Date \_\_\_\_\_ Employee's Signature **X** \_\_\_\_\_

**(over)**

## VISION CARE CLAIM INSTRUCTIONS

Check to see that all required information has been completed and that the form has been **signed**. Failure to completely fill out the form may **delay** payment of your claim.

### **FILING PROCEDURE:**

Claim forms are available from the Administrative Offices.

A claim form should be submitted for **each member** of the family for whom claims are made. A claim form should be filled out **each time** bills are submitted.

Completed claim forms, together with **itemized bills**, are to be sent to The Urman Company (address below).

**TIMELY CLAIMS SUBMISSION:** All claims are required to be submitted prior to July 1 of the next calendar year. If claims are not submitted within these guidelines, payment will not be assured.

### **ITEMIZED BILLS:**

Bills for services and treatment must include the information indicated below. Failure to submit complete bills will **delay** processing of your claim. Lists of expenses or statements of "Balance Due" are not acceptable.

**Physician or Optometrists** — Bills must show patient's name, date(s) of treatment, description of lenses and charges.

*MAIL CLAIMS TO:*

**CEBT/CNIC**

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**NOTE: PROVIDERS—FOR INFORMATION, PLEASE CALL (303) 773-1373**