Vision Claim Form

Please check the box next to your insurance company's name.

❑ Central United Life ❑ Manhattan Life ❑ Family Life

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 MUST BE SIGNED

Insured's Name	Social Security No.

Street Address	City or Town	State	Zip Code

Office Telephone No.	Date of Birth	Marital Status	Sex: Male ❑ Female ❑

IF A DEPENDENT CLAIM

Dependent's Name	Date of Birth	Relationship

Are you entitled to an income tax exemption for this dependent? Yes ❑ No ❑

If child, is he/she employed? Yes ❑ No ❑ Name of child's employer ______________________________

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

IMPORTANT: If child is full-time student, attach proof of full-time student enrollment.

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 ______________

DO YOU WANT US TO PAY BENEFITS TO YOUR PROVIDER?

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 ______________

Submit Completed Form to:
Claims Department
P.O. Box 925309
Houston, TX 77292-5309
Customer Service Department 1-800-669-9030
www.manhattanlife.com

VIS 0509

MANHATTAN INSURANCE GROUP

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PART B TO BE COMPLETED BY PROVIDER

Provider Name | Mailing Address | City, State, Zip

T.I.N. or E.I.N. | License No. | Telephone 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 any above, give brief description and dates.

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EXAMINATION	Description	Date	Code	Fee	Plan Allowance	Patient Responsibility

HAVE GLASSES BEEN PRESCRIBED? Yes ❑ No ❑

Description: ❑ Single Vision ❑Bifocal ❑Trifocal Bifocal/Trifocal Style:	Date	Code	Fee	Plan Allowance	Patient Responsibility

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: ❑ Hard ❑ Soft ❑ Gas Permeable ❑ Extended Wear ❑ Bifocal	Date	Code	Fee	Plan Allowance	Patient Responsibility

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 Number ____

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 ____________________
(Required)

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