VISION CLAIM FORM

MAIL TO: ADN
PO BOX 610
SOUTHFIELD, MI 48037

CITY OF BERKLEY

EMPLOYEE AND PATIENT INFORMATION

EMPLOYEE'S SOCIAL SECURITY NUMBER | EMPLOYEE'S NAME | DATE OF BIRTH

EMPLOYEE'S ADDRESS

PATIENT'S NAME

PATIENT'S RELATIONSHIP TO EMPLOYEE
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

OTHER INSURANCE COVERAGE
IS PATIENT COVERED BY ANOTHER VISION PLAN? ☐ YES ☐ NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER.

SOCIAL SECURITY NUMBER OF OTHER INSURED | NAME OF EMPLOYER

OTHER INSURED'S NAME | DATE OF BIRTH

IS THIS CONDITION CAUSED BY EMPLOYMENT? EXPLAIN

DOES CLAIM INVOLVE AN INJURY? ☐ YES ☐ NO

WAS PATIENT INJURED AT WORK? ☐ YES ☐ NO

DATE AND TIME OF INJURY________________________

I AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED DURING MY EXAMINATION OR TREATMENT.

SIGNED (EMPLOYEE OR PATIENT) DATE

I AUTHORIZE PAYMENT OF BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER OF SERVICES DESCRIBED BELOW.

SIGNED (EMPLOYEE OR PATIENT) DATE

TO BE COMPLETED BY SERVICE PROVIDER OR ATTACH A DETAILED RECEIPT OR CLAIM

DATE(S) OF SERVICE	SERVICE/PROCEDURE	DIAGNOSIS	CHARGE

BILLING ENTITY AND ADDRESS

TAX ID NUMBER

PHYSICIAN'S LICENSE NUMBER

PHONE NUMBER

SIGNATURE OF TREATING PHYSICIAN DATE