

VISION CLAIM FORM

PATIENT INFORMATION

1. EMPLOYEE'S SSN		GROUP NUMBER 597	GROUP NAME San Antonio Police Officers and Firefighters Benefit Plan & Trust
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTHDATE (mm/dd/yy) M <input type="checkbox"/> F <input type="checkbox"/>	4. EMPLOYEE'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. Street)		6. PATIENT RELATIONSHIP TO EMPLOYEE Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. EMPLOYEE'S ADDRESS (No. Street)
CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY
STATE	STATE	Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student <input type="checkbox"/>	STATE
ZIP CODE	TELEPHONE (Include Area Code) ()		ZIP CODE
TELEPHONE (Include Area Code) ()			TELEPHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO [] c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO d. PLEASE PROVIDE ACCIDENT DETAILS: _____	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. EMPLOYEE'S POLICY GROUP	
b. OTHER INSURED'S DATE OF BIRTH SEX (mm/dd/yy) M <input type="checkbox"/> F <input type="checkbox"/>		a. EMPLOYEE'S DATE OF BIRTH SEX (mm/dd/yy) M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. CLAIMS ADMINISTRATOR Boon-Chapman P. O. Box 9201 Austin, TX 78766 EDI PAYER ID #74238 1(800)936-7689	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (mm/dd/yy)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (mm/dd/yy)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (mm/dd/yy) TO (mm/dd/yy)						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. I.D. NUMBER OF REFERRING PHYSICIAN		19. HOSPITAL DATES RELATED TO CURRENT SERVICES FROM (mm/dd/yy) TO (mm/dd/yy)						
				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. _____ 2. _____ 3. _____ 4. _____				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER						
24. A DATE(S) OF SERVICE From (mm/dd/yy) To (mm/dd/yy)		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstance) CPT HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSOT Family Plan	I EMG	J COB
1										
2										
3										
4										
5										
6										
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____			32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)			33. PHYSICIAN/SUPPLIER BILLING ADDRESS: PH# _____ GRP# _____				