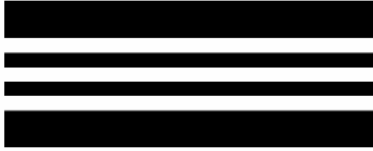


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DO NOT
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IN THIS
AREA



MAX VISION CARE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH <input type="checkbox"/> (ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																	
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY			STATE														
Z I P C O D E			TELEPHONE (Include Area Code)		Employee <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>					Z I P C O D E			TELEPHONE (INCLUDE AREA CODE)														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____					b. EMPLOYER'S NAME OR SCHOOL NAME																	
c. EMPLOYER'S NAME OR SCHOOL NAME					OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					c. INSURANCE PLAN NAME OR PROGRAM NAME																	
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																											
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.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																	
SIGNED _____ <i>Signature on file</i> DATE _____										SIGNED _____ <i>Signature on file</i>																	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					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					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1 THROUGH 6 BY LINE)										22. MEDICAID RESUBMISSION CODE - ORIGINAL REF. NO.																	
1. _____ 2. _____ 3. _____										Use the following Codes below: 92004, 92014, V2020, V2100, V2203, V2520, V2521, S0158																	
4. _____ 5. _____ 6. _____																											
24. A		B		C		D			E		F		G		H		I		J		K						
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/HCPCS MODIFIER			DIAGNOSIS CODE		\$ CHARGES		UNITS		EPSDT		N/A		ID QUAL		RENDERING PROVIDER ID						
1																	N/A		NPI								
2																	N/A		NPI								
3																	N/A		NPI								
4																	N/A		NPI								
5																	N/A		NPI								
6																	N/A		NPI								
25. FEDERAL TAX I.D. NUMBER				SSN		EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>				28. TOTAL CHARGE \$				29. AMOUNT PAID \$				30. BALANCE DUE \$			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)								32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)								33. PHYSICIAN'S, SUPPLIER'S BILLING & PHONE #				NAME, ADDRESS, ZIP CODE							
SIGNED _____								DATE _____								PIN# _____				GRP# _____							

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(APPROVED FOR USE WITH MAX VISION CARE 2009)