National Vision Administrators, L.L.C.

OUT OF NETWORK VISION CARE CLAIM FORM

Many NVA vision plans allow members the choice to visit a Participating Vision Care Provider or Non-participating Vision Care Provider. If you do decide to use a Non-participating Provider and your vision benefit allows out of network coverage, you can submit a direct claim to NVA for reimbursement according to your benefits. Please reference your NVA vision benefit to ensure you have out of network coverage.

VISION CLAIM FORM INSTRUCTIONS

- Use this form to obtain reimbursements for out of network services according to your plan design
- Part A to be completed by Employee
- Part B to be completed by your Eye Care Professional (Optional)
- Part C to be completed by your Eyewear Dispenser
- Scan and submit form by e-mail to: visionclaims@e-nva.com
- Submit the form by fax to: (973) 574-2430
- Submit the form by mail to: **National Vision Administrators, L.L.C.**
  P.O. Box 2187
  Clifton, New Jersey, 07015
- Include a copy of your receipts with your completed vision care claim form
- If you have any questions, please contact NVA at (800) 672-7723

VISION CARE CLAIM FORM

NVA VISION INSURANCE SERVICES ADMINISTRATORS
P.O. BOX 2187 / CLIFTON, NJ 07015
800-672-7723

"If you are a California resident, you have certain rights under California privacy laws regarding your personal information. To view your rights, please review our California Privacy Notice and Notice at Collection located at www.fslins.com"

PART A: TO BE COMPLETED BY EMPLOYEE

1. EMPLOYEE'S NAME (LAST, FIRST, MIDDLE)	2. EMPLOYEE'S ADDRESS (No., Street, City, State, Zip Code)	
3. EMPLOYEE'S IDENTIFICATION #	4. EMPLOYEE'S TELEPHONE #	
5. EMPLOYER'S NAME	6. EMPLOYER'S ADDRESS (No., Street, City, State, Zip Code)	
7. PATIENT'S NAME (LAST, FIRST, MIDDLE)	8. PATIENT'S GENDER	9. PATIENT'S DATE OF BIRTH

10. PATIENT RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ STUDENT ☐ HANDICAPPED OTHER: _____

11. PATIENT IS COVERED BY ANOTHER VISION PLAN ☐ YES ☐ NO	PLAN NAME	GROUP #

12. NAME AND ADDRESS OF OTHER VISION CARRIER

California: *For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.*

PART B: TO BE COMPLETED BY EYE CARE PROFESSIONAL (OPTIONAL)

1. DOCTOR'S NAME (LAST, FIRST, MIDDLE)	2. TITLE	☐ MD	☐ DO	☐ OD	3. TAXPAYER IDENTIFICATION #
4. DOCTOR'S ADDRESS (No., Street, City, State, Zip Code)					5. BUSINESS PHONE # (area code)

6. TYPE OF SERVICE	7. COST $	8. EXAM DATE	9. AMT PAID BY PATIENT $	9. CATARACT SURGERY PERFORMED ☐ YES ☐ NO

10. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN THE BETTER EYE WITH CONVENTION EYEGLASSES? ☐ YES ☐ NO

11. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? ☐ YES ☐ NO

12. DIAGNOSTIC CODE(s)	14. VISUAL ACUITY CORRECTED TO:

13. INDICATE DIAGNOSIS OR NATURE OF DISEASE, INJURY, VISION DISORDER. CODE #'S INDICATE PROCEDURE

15. DOCTOR'S PRESCRIPTION

SPHERE		CYLINDER	AXIS	PRISM	BASE
R.E.		●			
L.E.		●			
READING ADD		R.E.	+ ●	L.E.	+ ●

16. I hereby certify that I have performed the services as indicated heron.

DOCTOR'S SIGNATUR DATE

PART C: TO BE COMPLETED BY DISPENSER

1. DISPENSER'S NAME (LAST, FIRST, MIDDLE)			2. TAXPAYER IDENTIFICATION #	
3. DISPENSER'S ADDRESS (No., Street, City, State, Zip Code)			4. BUSINESS PHONE # (area code)	
5. DATE RANGE OF SERVICE (MM/DD/YY)	6. PLACE OF SERVICE		7. TYPE OF SERVICE	8. DIAGNOSIS CODE
9. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances)	CPT/HCPC	MODIFIER	10. CHARGES $	11. DAYS OR UNITS
12. DATE RANGE OF ADDITIONAL SERVICES	13. PLACE OF SERVICE		14. TYPE OF SERVICE	15. DIAGNOSIS CODE
16. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances)	CPT/HCPC	MODIFIER	17. CHARGES $	18. DAYS OR UNITS

19. PATIENT'S ACCOUNT #	20. TOTAL CHARGED $	21. AMOUNT PAID $	22. BALANCE DUE $

23. I HEREBY CERTIFY THAT I HAVE PROVIDED THE SERVICES AS INDICATED HEREON

DISPENSER'S SIGNATURE DATE

PLEASE PRINT INFORMATION

Scan and submit via e-mail: visionclaims@e-nva.com or submit via fax at 973-574-2430