SouthlandBenefit
Administrators
A Division of Southland National Insurance Corporation

VISION CLAIM FORM

CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 365 DAYS FROM DATE OF SERVICE.

PART A — PATIENT INFORMATION (TO BE COMPLETED BY EMPLOYEE)

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. SUBSCRIBER'S NAME, ADDRESS AND PHONE NO.

FULL TIME STUDENT
☐ YES ☐ NO IF YES, WHERE

4. PATIENT'S ADDRESS *(If different from subscriber)*

5. PATIENT'S SEX
☐ MALE ☐ FEMALE

6. SUBSCRIBER'S CONTRACT NO.

7. PATIENT'S RELATIONSHIP TO INSURED
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

8. SUBSCRIBER'S GROUP

9. OTHER VISION INSURANCE COVERAGE - ☐ YES ☐ NO
If Yes, Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO
B. AN ACCIDENT ☐ YES ☐ NO

11. IF AN ACCIDENT
date__________________, 20______ and time________ ☐ A.M. ☐ P.M.
description (how & where) ______________________________

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I Authorize the Release of any Information Necessary to Process this Request.
SIGNED DATE

13. *I AUTHORIZE PAYMENT OF VISION CARE BENEFITS TO UNDERSIGNED PHYSICIAN OR OPTOMETRIST FOR SERVICE DESCRIBED IN PART B BELOW.*
SIGNED (Subscriber or Authorized Person)

14. *I HEREBY AUTHORIZE PAYMENT OF VISION CARE BENEFITS TO THE UNDERSIGNED SUPPLIER FOR SERVICES DESCRIBED IN PART C BELOW.*
SIGNED (Subscriber or Authorized Person)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

PART B — EXAMINING PHYSICIAN OR OPTOMETRIST INFORMATION

Indicate diagnosis or nature of disease or injury or vision disorder

REPORT OF SERVICES (OR ATTACH AN ITEMIZED BILL)

Date of Service	Services Rendered	Refraction Included	Charge
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Physician's or Optometrist's name, address & zip code
☐ Ophthalmologist
☐ Optometrist

Total Charge

Telephone No.

Your Social Security No.

Signature of Physician or Optometrist

Date Signed

Your Employer I.D. No.

PART C — SUPPLIER INFORMATION (To be completed by dispenser of prescription)

Date of Service:______________________

Type of Lens	No. of Lens	Charge	Extra Charge for Photosensitive or Anti-reflective
Single Vision		$	$
Bifocal			
Trifocal			
Lenticular			
Contact . . ☐ Soft . . ☐ Hard			
Oversize			
Sunglasses			
Tint No.			
Other			
Were Contacts Disposable? ☐ Yes ☐ No	TOTAL LENS CHARGE	$	$
	FRAMES CHARGE	$	$

(Must be Furnished Under Authority of Law)

Name of Supplier ______________________ SS No. [ ] Employer I.D. No. [ ]

Address:____
Street City State Zip Code

Signature:______________________ Date:__________ Telephone No.:__________