



FOR OFFICE USE ONLY

Claims Processing Unit
PO Box 100300
Columbia, South Carolina 29202

VISION CLAIM FORM

Before completing this form, see reverse for instructions. Use a separate claim form for each patient.

1. Member's Identification Number
2. Member's Name First M. Last
3. Home Telephone Number Area Code
4. Check box for new address
5. Member's Address Street Apt. No. City State Zip Code
6. Employer's Name and Address
7. Patient's Name First M. Last
8. Patient's Birthdate Mo. Day Yr.
9. Sex Male Female
10. Relationship to Member Self Spouse Child Other

11. Diagnosis or condition requiring treatment.

12. Was any treatment required as the result of accidental injury? Was another person at fault? If yes, please attach a statement explaining details of accident to this form.

13. Was any injury or illness work-related? If yes, was a Workers Compensation Claim filed?

14. Is the patient covered by Medicare Health Insurance, Part A? Or by Supplemental Medical Insurance, Part B? If yes, please complete the following: Part A: HIB Number Part B: HIB Number

15. Is the patient covered under any other group health insurance plan (including but not limited to CHAMPUS or Federal Employee Program (FEP)? a. Name and Address of Other Insurance Company: b. Name of Policyholder: Relationship to Patient: Policy Number: Effective Date: Name and Address of Employer:

Provider should complete shaded areas - Otherwise, member must attach itemized bills.

Table with 4 columns: Procedure Code, Exam, Procedure Code, Frames. Rows include M934E, M934F, M934G, M934H, M934I with corresponding exam descriptions and procedure codes.

17. To be completed if contacts are medically required. Surgery Date: Other necessity - visual acuity in better eye corrected to: with glasses with contacts.

Table with 7 columns: Line, Date of Service, Procedure Code (from above), Provider Number, Diagnosis, Med. Nec., Charge, EOB. Includes a summary row for Total Lines, Total Charge, PE, MSG, AUTH.

19. Provider Name, Street Address, City and State, Signature of Provider, Date, Provider's Signature

20. CERTIFICATION OF MEMBER. I certify that the above information is correct and that I am claiming benefits only for charges incurred by the patient named above. Date, Member's Signature

# CONTRACTUAL NOTES

**Benefits are provided for the following medically necessary services or supplies performed or prescribed by a physician.**

1. Routine eye examinations, limited to one a year, unless medical documentation warrants otherwise.
2. Lenses, as follows, limited to one pair per member per contract year:
  - a. Single Vision
  - b. Bifocals
  - c. Trifocals
  - d. Aphakic:
    - (1) glass
    - (2) plastic
    - (3) aspheric
  - e. Lenticular
  - f. Contacts, hard or soft, only following cataract surgery or when visual acuity is not otherwise correctable to at least 20/70 in the better eye.
3. Frames, limited to one set per member in a 24-month period.

## FILING TIPS

**If entire claim is completed by the member an itemized bill from the provider must accompany the claim form.**

### **MAKE SURE EVERY ITEMIZED BILL SHOWS THE FOLLOWING:**

- \* Name and Address of provider or supplier rendering services.
- \* Type of each service or supply.
- \* Date each service or supply was received.
- \* Amount charged for each service or supply.
- \* Patient's Name.

**Mail completed claim form and itemized bills (if necessary) to:**

**Blue Cross and Blue Shield of South Carolina  
Vision Processing Unit – PO Box 100300  
Columbia, S.C. 29202-3300**

### **SPECIFIC INSTRUCTIONS FOR COMPLETING ITEMS 1 THROUGH 20 ON THIS FORM (\* indicates provider completion)**

1. Member's Identification Number: Number appearing on Identification Card.
2. Member's Name: Name appearing on Identification Card.
3. Home Telephone Number: Area code and number.
4. Check this block if address is new and you want our records corrected.
5. Member's Address: Complete mailing address.
6. Employer's Name and Address: Do not complete if you hold an individual contract.
7. Patient's Name: Patient's first, middle initial and last name. Please do not use nickname. Always use the same name when filing, e.g., Mary J. always file as Mary J.
8. Patient's Birthdate: Patient's month, day and year of birth.
9. Patient's Sex: Check appropriate box.
10. Patient's Relationship to Member: Check appropriate box. If other, please specify such as "foster child," "student," etc.
11. Diagnosis: Indicate condition for which all treatment was rendered in this section, or indicate by charge on itemized statement for what condition treatment was given.
12. Accidental Injury: Check appropriate box. Give date of accident. If another person was at fault, attach a statement explaining details of the accident.
13. Work-related: Check appropriate box.
14. Medicare Healthcare Benefits: If the patient is covered by Medicare Health Insurance, Part A or Supplemental Medical Insurance, Part B, please complete this section.
15. Other Health Insurance Coverage: If patient is covered under any other group health insurance plan, this section should be completed in as much detail as possible. If any benefits have been paid by the other insurance, please attach a copy of their Notice of Payment.
- \*16. To be completed by the provider.
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- \*18. To be completed by the provider using procedure codes indicated in item 16.
- \*19. Signature – Complete name and address of provider and obtain provider's signature.
20. Signature – Signature of patient (unless minor) and member.