

Group Vision Care Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare



MAIL THIS FORM TO: CIGNA HealthCare
P.O. Box 5200
Scranton, PA 18505-5200

TELEPHONE: 1.800.CIGNA24 Toll Free

EMPLOYEE'S INSTRUCTIONS FOR FILING A VISION CARE CLAIM

Any person who knowingly and with intent to defraud any insurance company or other person 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.

USE A SEPARATE FORM FOR **EACH** MEMBER OF THE FAMILY FOR **EACH** SEPARATE CLAIM.

- COMPLETE EVERY ENTRY ON THIS FORM IN THE SECTION ENTITLED "TO BE COMPLETED BY EMPLOYEE".
- CLAIM WILL BE DELAYED IF SOCIAL SECURITY NUMBER IS NOT COMPLETED.
- HAVE YOUR DOCTOR COMPLETE THE SECTION ENTITLED "TO BE COMPLETED BY THE DOCTOR".
- ASK OTHER PROVIDERS OF SERVICE TO GIVE YOU AN ITEMIZED BILL WHICH INCLUDES:
- Patient's Name - Type of Service - Date of Service - Charge for Each Service or Supply.
- SAVE YOUR BILLS until you have received all bills for that sickness or accident.
- Send this form and your bills to address shown at the top of this form.
- INDICATE YOUR EMPLOYER'S NAME ON ALL CORRESPONDENCE.

TO BE COMPLETED BY THE EMPLOYEE

A. EMPLOYER INTER-AMERICAN DEVELOPMENT BANK		ACCOUNT NUMBER 3206628
B. PLANT LOCATION/DIVISION		DATE HIRED
		<input type="checkbox"/> Hourly <input type="checkbox"/> Salaried
C. EMPLOYEE NAME	DATE OF BIRTH	D. EMPLOYEE'S SOC. SEC. NO.
E. ADDRESS (Street, City, State, Zip)	F. HAS COVERAGE EVER BEEN TERMINATED? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, GIVE REASON AND DATE OF TERMINATION
G. NAME OF SPOUSE	SPOUSE'S DATE OF BIRTH	H. SPOUSE'S SOC. SEC. NO.
I. SPOUSE EMPLOYED - IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS <input type="checkbox"/> Yes <input type="checkbox"/> No	J. NAME AND ADDRESS OF SPOUSE'S EMPLOYER	
K. ARE YOU OR YOUR DEPENDENT COVERED UNDER ANY OTHER GROUP OR GOVERNMENT PLAN SUCH AS MEDICARE, OR UNDER AUTOMOBILE MANDATORY NO-FAULT COVERAGE, WHICH WILL ALSO PAY FOR ANY OF THE EXPENSES OF THIS CLAIM? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, GIVE NAME OF INSURANCE COMPANY OR ORGANIZATION PROVIDING BENEFITS.		
NAME	ADDRESS	POLICY NUMBER
L. IS THIS ACCIDENT OR SICKNESS DUE TO EMPLOYMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	M. CLAIM IS MADE FOR <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	NAME OF PATIENT First Last
N. PATIENT DATE OF BIRTH	PATIENT ADDRESS (Street, City, State, Zip)	IF FULL TIME STUDENT School City
O. WAS VISION CARE REQUIRED BECAUSE OF AN INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No	WAS INJURY CAUSED BY YOUR WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No	HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKERS' COMPENSATION CARRIER? <input type="checkbox"/> Yes <input type="checkbox"/> No

I hereby authorize any physician, hospital, pharmacy, insurance company, employer or organization to release any information necessary to process this claim to the Plan Administrator or its authorized agent. I understand that I or my authorized representative will receive a copy of the authorization upon request.

SIGN HERE → Patient or parent/guardian signature _____ Date _____

I hereby authorize payment directly to the undersigned doctor of the Vision Care benefits otherwise payable to me and to the supplying or dispensing optician for the ophthalmic materials and related charges according to the attached invoice.

Date _____ Signature of employee _____

TO BE COMPLETED BY THE DOCTOR

1. Has patient worn glasses before this examination? Yes No Type _____ Date of Prev. Exam. _____
2. If Yes, state reason for replacement _____
3. Does your examination indicate that glasses should be prescribed? Yes No Does Rx change more than .5 diopters or 10% in axis for astigmatism? Yes No
4. If you prescribe glasses, check type: Single Vision Bifocal Trifocal
Other (Describe) _____
5. Did exam include refraction? Yes No
6. Has cataract surgery been performed? Yes No Date _____
7. Can visual acuity be restored to at least 20/70 in the better eye with conventional glasses? Yes No

	Diagnosis Code	CPT4 Code	Dates of Service	Charges	
8. EXAMINATIONS				\$	Date Service Began _____
A. Vision Survey					Date Service Completed _____
B. Complete Visual Analysis (^{With} Tonometry)					Doctor's Name _____
C. Complete Visual Analysis (^{Without} Tonometry)					
9. MATERIALS & PROFESSIONAL SERVICES					Doctor's Address _____
A. Single Vision Lenses					I hereby certify that examinations have been completed and materials and services rendered as stated in this Part. Doctor's Signature _____ SS# or Tax ID# _____ Date _____
B. Bifocal Lenses					
C. Trifocal Lenses					
D. Lenticular Lenses					
E. Contact Lenses, for Each Lens					
F. Frame					
G. Oversize					
H. Sunglasses					
I. Tint No.					
J. Photosensitive or Anti-reflective (Extra Charge)					
TOTAL					