Claims Processing Unit
PO Box 100300
Columbia, South Carolina 29202

VISION CLAIM FORM

FOR OFFICE USE ONLY

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 If 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? ☐ Yes ☐ No
Was another person at fault? ☐ Yes ☐ No If yes, please attach a statement explaining details of accident to this form.

13. Was any injury or illness work-related? ☐ Yes ☐ No If yes, was a Workers Compensation Claim filed? ☐ Yes ☐ No

14. Is the patient covered by Medicare Health Insurance, Part A? ☐ Yes ☐ No Or by Supplemental Medical Insurance, Part B? ☐ Yes ☐ No
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)?
☐ Yes ☐ No If yes, please complete the following:

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.

16.

Procedure Code	Exam	Procedure Code	Frames
M934E	Visual acuity, Ophthalmoscopy, Tonometry, gross visual fields muscle balance and slit lamp microscopy.	G0086	Pair
M934F	With refraction.		Lenses ☐ Right ☐ Left ☐ Pair
M934G	With plotting central and/or peripheral visual fields.	G0054	Single
M934H	With refraction and plotting of central and/or peripheral visual fields.	G0056	Bifocal
		G0058	Trifocal
M934I	With refraction, Keratometry and diagnostic services for contact lenses.	G0032	Aphakic (plastic)
		G008C	Contact

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

18.

Line	Date of Service	Procedure Code (from above)	Provider Number	Diagnosis	Med. Nec.	Charge	EOB
1							
2							
3							
4							
	Total Lines		Total Charge			PE	MSG	AUTH

19. Provider Name ____________

Street Address ____________

City and State ____________

Signature of Provider

(I hereby certify that the procedures as indicated above have been completed by me or under my direct supervision.)

Date ________ Provider's Signature ____________

(Not required if filed by member.)

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. Authorization is hereby given to any provider which participated in any way in my care and treatment to release to Blue Cross and Blue Shield of South Carolina any medical information which they in their judgment deem necessary to the adjudication of this claim.

Date ________ Member's Signature ____________

(Not required if filed by member.)

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.
*17. To be completed by the provider.
*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.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در بارهٔ این برنامهٔ بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شمارهٔ 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)