Vision Claim Form

Please check the box next to your insurance company's name.

❑ ManhattanLife Insurance and Annuity ❑ Manhattan Life

CAUTION: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

PART A TO BE COMPLETED BY PATIENT (INSURED) IMPORTANT: ALL QUESTIONS MUST BE COMPLETED AND FORM MUST BE SIGNED

Insured's Name | Social Security No.

Street Address | City or Town | State | Zip Code

Office Telephone No. | Date of Birth | Marital Status | Sex: Male ❑ Female ❑

IF A DEPENDENT CLAIM

Dependent's Name | Date of Birth | Relationship

Are you entitled to an income tax exemption for this dependent? Yes ❑ No ❑

If child, is he/she employed? Yes ❑ No ❑ Name of child's employer _____

Sex: Male ❑ Female ❑ If child is over 19 years old, is child a full-time student? Yes ❑ No ❑

IMPORTANT: If child is full-time student, attach proof of full-time student enrollment.

Are you or your dependent entitled to benefits under: Any other vision plan? Yes ❑ No ❑ Medicare? Yes ❑ No ❑

If yes, name of family member holding policy _____ Policy No. _____

Name and address of employer, union, association, school, etc., carrying other plan

Name and address of other insurance company

PLEASE SIGN AND DATE AUTHORIZATION

I accept this claim form and authorize release of information relating hereto. I certify the truth of all personal information contained above and that all the services listed above have been completed/delivered. I agree to be responsible for the applicable co-payment as detailed in my Group program, for any services indicated as rendered. I also agree to be responsible for any and all services which may be rendered but not eligible for coverage under my Group Program.

Patient (Parent or Subscriber Signature) _____ Date _____

DO YOU WANT US TO PAY BENEFITS TO YOUR PROVIDER?

Authorization to Pay Benefits to Provider

I hereby authorize payment directly to the Provider of the Vision Benefits for the services as described on this claim but not to exceed the scheduled amount of covered vision care expenses for these services.

Insured Person (Signature) _____ Date _____

Submit Completed Form to:

Claims Department
P.O. Box 924408
Houston, TX 77292-4408

Customer Service Department 1-800-999-2971
www.manhattanlife.com

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PART B TO BE COMPLETED BY PROVIDER

Provider Name | Mailing Address | City, State, Zip

T.I.N. or E.I.N. | License No. | Telephone No.

1. Is exam required as condition of employment? Yes ☐ No ☐
2. Is exam the result of occupational injury? Yes ☐ No ☐
3. Is exam the result of auto accident? Yes ☐ No ☐
4. Other accident? Yes ☐ No ☐

If Yes to any above, give brief description and dates.

EXAMINATION	Description	Date	Code	Fee	Plan Allowance	Patient Responsibility

HAVE GLASSES BEEN PRESCRIBED? Yes ☐ No ☐

Description: ☐ Single Vision ☐ Bifocal ☐ Trifocal Bifocal/Trifocal Style:	Date	Code	Fee	Plan Allowance	Patient Responsibility

Prescription:

	Sphere	Cylinder	Axis	Prism	Base	Base Curve
R						
L						

	Bifocal Add	Height	Width	Pupillary Width	Reading	Distance
R						
L						

FRAMES: Mfg. Name & Style: _____

HAVE CONTACT LENSES BEEN PRESCRIBED? Yes ☐ No ☐

Description: ☐ Hard ☐ Soft ☐ Gas Permeable ☐ Extended Wear ☐ Bifocal	Date	Code	Fee	Plan Allowance	Patient Responsibility

Prescription:

Hard or Soft Daily Wear Contact Lenses

	Base Curves	Lens RX	Lens Size	2nd Curve Width	P.C. Width	2nd Curve Radius	P.C. Radius	O.Z.	Tint
R									
L									

Gas Permeable or Extended Wear Contact Lenses

	Lens RX	Lens Size	Type or Mfg.	Add	Seg. Hgt.
R					
L					

BIFOCAL CCL.
Bifocal Style

RAM
Crescent
Curve Top
One Piece

Manufacturer & Style Number _____

The services listed above are the only services considered for possible benefits under your vision care plan. Payment of these services is subject to current eligibility on the date services are completed/delivered.

I hereby certify that the services as indicated by the date listed have been completed/delivered and that the fees submitted are the actual fees charges and intended to be collected for these services. Payment is requested in accordance with the rules and regulations of The Health Application Network

Provider Signature _____ Date _____
(Required)

Submit Completed Form to:

Claims Department
P.O. Box 924408
Houston, TX 77292-4408

VIS 0509

Customer Service Department 1-800-999-2971
www.manhattanlife.com

ManhattanLife™

Claim Form Addendum: Fraud Warning and State Versions

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Alaska** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **Arkansas** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Arizona** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. **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. **Colorado** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Delaware** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. **District of Columbia** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **Florida** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **Idaho** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **Indiana** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. **Kentucky** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim 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. **Louisiana** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Maine** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **Maryland** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Minnesota** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **New Hampshire** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20. **New Jersey** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **New Mexico** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **New York** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **Ohio** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Oklahoma** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Pennsylvania** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties. **Puerto Rico** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. **Rhode Island** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Tennessee** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **Texas** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Virginia** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **Washington** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. **West Virginia** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

How to File a Claim for Your Vision Policy

Vision

Purchases made from retail or online stores

Most vision care (Exams, eyeglasses, frames, lenses, and contacts) are purchased at a retail location, such as Lenscrafters, Costco, Walmart and independent retailers. You may be required to pay first and file your claim yourself. Sometimes vision care is purchased from online stores, such as 1800contacts.com, coastal.com or lens.com. If you purchase online you will need to print out the itemized paid receipt provided by the retailer and submit with your completed claim form.

Claim Filing

We accept the HCFA 1500 (Health Care Financial Administration) standardized health insurance claim form or the Vision Claim Form at **www**.manhattanlife.com

Your policy will consider charges for basic eye exams, refractions, eyeglasses and contact lenses.

In the information section of the form, you or your physician must fill in the following information.

- Insured's full name and address
- Insured's ID Number
- The name and date of birth of the insured receiving the vision services.

If your vision care provider files the claim for you Many ophthalmologist and optometrists will file the claim on your behalf. Many may ask that you pay your share of the cost at the time of the visit. Show your ManhattanLife Assurance Company of America ID card to your vision care provider.

All claims be submitted to ManhattanLife Assurance Company of America by mail or fax.

ManhattanLife Assurance Company of America
Worksite Division
P.O. Box 924408
Houston, Texas 77292-4408
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