

# Vision Claim Form

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

ManhattanLife Assurance  Manhattan Life  Family 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 <input type="checkbox"/> Female <input type="checkbox"/>

**IF A DEPENDENT CLAIM**

Dependent's Name	Date of Birth	Relationship
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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 925309  
Houston, TX 77292-5309

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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
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**HAVE GLASSES BEEN PRESCRIBED?** Yes  No

Description: <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal	Date	Code	Fee	Plan Allowance	Patient Responsibility
Bifocal/Trifocal Style: _____					

**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: <input type="checkbox"/> Hard <input type="checkbox"/> Soft <input type="checkbox"/> Gas Permeable <input type="checkbox"/> Extended Wear <input type="checkbox"/> Bifocal	Date	Code	Fee	Plan Allowance	Patient Responsibility
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**Prescription:**

Hard or Soft Daily Wear Contact Lenses

	Base Curves	Lens RX	Lens Size	2 <sup>nd</sup> Curve Width	P.C. Width	2 <sup>nd</sup> 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 925309  
Houston, TX 77292-5309



### 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 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.