Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

Claims submitted for: ☐ Exam only ☐ Materials only ☐ Exam and materials (please check only one box)
Please forward claims to: Blue Shield of California, P.O. Box 25208, Santa Ana, CA 92799-5208. **(877) 601-9083** members or **(800) 877-6372** providers

Vision claim form

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

Note: Please complete the entire form. This form cannot be processed if information is incomplete. **Important:** Please print all sections in black ink.

Section 1 – Employee/patient to complete and sign this section

Patient's name (last name first)	Gender ☐ Male ☐ Female	Employee identification number
Employee's name	Relationship to employee ☐ Self ☐ Spouse/Dom. partner ☐ Child	Patient's birthdate (mm/dd/yy)
Street address	Name of employer	Group number
City, State and ZIP code		

Other vision coverage? If "Yes," give name of carrier and policy number
☐ Yes ☐ No

Was care required because of an injury or illness? If "Yes," please explain
☐ Yes ☐ No

If dependent age over contract age limit, are they a full-time student? ☐ Yes ☐ No

Check condition(s) patient is known to have: ☐ Diabetes ☐ Diabetic Retin ☐ Hypertension ☐ Glaucoma ☐ ARMD ☐ Arcus ☐ None

The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize my doctor to furnish and disclose all facts concerning this claim. I hereby assign payable benefits to participating providers.

Patient signature _____ Date_____

Section 2 – to be completed by doctor

Date of examination	Refraction		
	No refraction		

If you prescribed glasses, check the type
☐ Single vision ☐ Bifocal ☐ Trifocal ☐ Progressive ☐ Contact lens

Has cataract surgery been performed?
☐ Yes ☐ No Date:_____

Has laser surgery been performed?
☐ Yes ☐ No Date: _____
Note: Proof of Laser surgery may be required for sunglass benefit.

Is this a prescription change from last year?
☐ Yes ☐ No

Best corrected visual acuity
R.E. 20/ L.E. 20/

RVS/CPT	Examination fee $	RVS/CPT	Other charges

Doctor's prescription

	Sphere	Cylinder	Axis	Prism	Base
R.E.	•	•			
L.E.	•	•			

Reading ADD	R.E.	+ •	L.E.	+ •

Special instructions: in order to use this form: the participating provider must call mes for eligibility verification at **(800) 877-6372**

Signature	Date
Please type or print name of doctor	Participating provider number
Street address	
City, State, and ZIP code	
Exam eligibility verification number	

Section 3 – to be completed by dispenser

Date of order Date of delivery	☐ Single vision ☐ Trifocal ☐ Contacts ☐ Bifocal ☐ Progressive
Right lens charge	$
Left lens charge	$
Oversize charge, if any	$
☐ Prism charge ☐ other ☐ Slab off charge _____	$
Tint charge Color _____ No. _____	$
Frame charge Name of frame _____	$
Is frame size less than:	61mm ☐ 56mm ☐
Contact lens charge ☐ Hard ☐ Soft	$
Plano sunglasses (Prefabricated or Non-prescription)	$
Total for optical materials	$
Comments	

Signature	Date
Please type or print name of dispensary	Participating provider number
Street address	
City, State, and ZIP code	
Materials eligibility verification number	

An Independent Member of the Blue Shield Association C4669-61-FF (3/09)