**EBSO, Inc.**
**VISION BENEFITS CLAIM FORM**
**800-558-7798 Customer Service**

**INSTRUCTIONS FOR FILING YOUR CLAIM:**

1. COMPLETE PART A BELOW.
2. SIGN AUTHORIZATION ON BACK OF FORM IF YOU WISH PAYMENT TO BE MADE DIRECTLY TO THE PROVIDER.
3. HAVE YOUR PROVIDER COMPLETE PART B ON BACK OF FORM AND RETURN TO YOU.
4. ATTACH ANY ADDITIONAL VISION BILLS.

**PART A**

EMPLOYEE'S STATEMENT OF CLAIM FOR GROUP VISION INSURANCE BENEFITS

I HEREBY PRESENT THIS CLAIM, AND AUTHORIZE ANY INDIVIDUAL OR ORGANIZATION TO RELEASE INFORMATION REQUIRED FOR ITS ACCEPTANCE.

1. CLAIM IS BEING MADE FOR:
   - ☐ Self
   - ☐ Unmarried child. If age 19 or over, insurance continued as ☐ Full time student attending_____
   - ☐ Wife/Husband
   - ☐ Other (Specify)_____

| 2. PATIENT'S NAME | DATE OF BIRTH | SEX ☐ Male ☐ Female |
|---|---|---|
| | | |

3. IS THIS CLAIM THE RESULT OF A WORK RELATED ILLNESS OR INJURY? ☐ YES ☐ NO

| 4. ARE YOU (EMPLOYEE) MARRIED? ☐ YES ☐ NO | 4a. IS YOUR WIFE/HUSBAND EMPLOYED? ☐ YES ☐ NO<br>Employer Name<br>Employer Address<br>Spouse SS# | 4b. IF CLAIM IS FOR A DEPENDENT CHILD, IS THIS CHILD EMPLOYED? ☐ YES ☐ NO<br>Employer Name<br>Employer Address<br>Spouse SS# |
|---|---|---|

5. IS PATIENT ALSO COVERED FOR ANY OTHER INSURANCE BENEFITS AS LISTED BELOW, EITHER AS AN EMPLOYEE OR DEPENDENT? ☐ YES ☐ NO

If Yes, check box below which applies and complete 5a.

- ☐ Group health insurance of any kind including Blue Cross and Blue Shield.
- ☐ Coverage of vision care expenses provided by an employer, a union welfare plan, any federal, state, provincial or other governmental program
- ☐ Other arrangement of benefits for individuals or a group.

5a. GIVE NAME AND ADDRESS OF OTHER COMPANY OR ORGANIZATION PROVIDING INSURANCE:

Name

Address

Other insurance or Blue Cross/Blue Shield Group No.(s)

| 6. EMPLOYER'S/COMPANY'S NAME | GROUP NUMBER | EMPLOYER'S ADDRESS |
|---|---|---|
| | | |

| 7. EMPLOYEE'S NAME (PRINT OR TYPE) | SOCIAL SECURITY NUMBER | DATE OF BIRTH |
|---|---|---|
| | | |

| STREET NO. | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

**SEND CLAIM TO: EBSO, Inc. ; P.O. BOX 928; FINDLAY, OH 45839**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE

DATE

**PART B**

| AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the undersigned Provider of Vision Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for this services. | SIGNED (INSURED PERSON) _____ _____ DATE |
|---|---|

**TO BE COMPLETED BY THE DOCTOR OR PROVIDER OF SERVICE**

| PATIENT'S NAME AND ADDRESS | DATE OF BIRTH |
|---|---|
| DIAGNOSIS AND CONCURRENT CONDITIONS | |

**REPORT OF SERVICES (OR ATTACH ITEMIZED BILL)**

| DATE OF SERVICES | PLACE OF SERVICES | DESCRIPTION OF SERVICES RENDERED | CHARGES |
|---|---|---|---|
| | | EXAMINATION | |
| | | LENSES: | |
| | | SINGLE ☐ ONE ☐ TWO | |
| | | BIFOCAL ☐ ONE ☐ TWO | |
| | | TRIFOCAL ☐ ONE ☐ TWO | |
| | | LENTICULAR ☐ ONE ☐ TWO | |
| | | CONTACTS* ☐ ONE ☐ TWO | |
| | | FRAMES | |

+O - Doctor's Office IH - Inpatient Hospital NH - Nursing Home

H - Patient's Home OH - Outpatient Hospital OL - Other Locations

TOTAL CHARGES $ _____

AMOUNT PAID $ _____

BALANCE DUE $ _____

IS THIS IS A REPLACEMENT? ☐ YES ☐ NO

IF YES, PLEASE GIVE REASON FOR REPLACEMENT:

_____

_____

_____

*FOR CONTACT LENSES:

MEDICALLY NECESSARY ☐ YES ☐ NO

COSMETIC ☐ YES ☐ NO

VISUAL ACUITY _____ OD _____ OS

| DATE | DEGREE | INDIVIDUAL PRACTIONER SOCIAL SECURITY NUMBER |
|---|---|---|
| PHYSICIAN/SUPPLIER NAME | TELEPHONE NUMBER | ALL OTHERS - EMPLOYER ID NUMBER |
| PHYSICIAN'S SIGNATURE | | *MUST BE FURNISHED UNDER AUTHORITY OF LAW* |

| STREET ADDRESS | CITY OR TOWN | STATE | ZIP CODE |
|---|---|---|---|