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Mail Claims To:

**UnitedAg**  
P.O. Box 2399  
Montclair, CA 91763

## VISION CARE SERVICE CLAIM FORM

**IMPORTANT: PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS**

TO BE COMPLETED BY EXAMINING PHYSICIAN											
PATIENT'S NAME (LAST NAME FIRST)				COV. CODE	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female			SOCIAL SECURITY NO. - -			
SUBSCRIBER'S ADDRESS First Name: _____ Last Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____					RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child			PATIENT'S BIRTHDATE / /			
					NAME OF GOVERNMENT PROGRAM (if applicable)			ACCOUNT NO. OR NAME			
OTHER MEDICAL COVERAGE? IF "YES", INDICATE NAME OF CARRIER											
THIS CONDITION IS CAUSED BY: <input type="checkbox"/> ILLNESS <input type="checkbox"/> INJURY				IF INJURY, DATE SUSTAINED, HOW AND WHERE SUSTAINED:							
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO											
IF YOU PRESCRIBED GLASSES, CHECK TYPE: <input type="checkbox"/> SINGLE VISION <input type="checkbox"/> BIFOCAL <input type="checkbox"/> TRIFOCAL				TINT PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO		PHYSICIAN'S PRESCRIPTION					
HAS CATARACT SURGERY BEEN PERFORMED? IF YES, PLEASE DATE. <input type="checkbox"/> YES <input type="checkbox"/> NO DATE: _____				R.V.S. NO. or DIAGNOSIS:		Sphere		Cylinder	Axis	Prism	Base
						Right Eye					
CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO						READING ADDITION		Right Eye		Left Eye	
						Left Eye					
PHYSICIAN'S NAME AND ADDRESS First Name: _____ Last Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____					PHYSICIAN SPECIALTY		IRS TAXPAYER'S NO.		EXAMINATION DATE OF SERVICE		
					PHYSICIAN PHONE NO.		COUNTY		EXAMINATION FEE		
PHYSICIAN'S SIGNATURE: _____					DATE: _____		CERTIFICATE NO.		\$		

TO BE COMPLETED BY SUPPLIER OF LENSES OR FRAMES										
LENSES & FRAME <input type="checkbox"/>		BIFOCALS <input type="checkbox"/>		Name of Frame Type: _____		DATE:	\$	SUPPLIER'S ADDRESS First Name: _____ Last Name: _____		
FRAME ONLY <input type="checkbox"/>		LENSES ONLY <input type="checkbox"/>		CONTACT LENSES (choose 1) <input type="checkbox"/> Therapeutic <input type="checkbox"/> Cosmetic		DATE:	\$	Address: _____ City: _____ State: _____ Zip Code: _____		
OTHER: (i.e. Shatter proofing. Please specify below) <input type="checkbox"/> _____						DATE:	\$	IRS TAXPAYER'S NO.		
WERE ANY OF THE ABOVE CHARGES FOR SUNGLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO						TOTAL: \$		AUTHORIZED SIGNATURE OF SUPPLIER		DATE

<p><i>The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize this physician or supplier to furnish and disclose all facts concerning this service.</i></p> <p>_____ Signature</p> <p>_____ Date</p>	<p><i>I authorize payment of medical benefits to above signed physician or supplier for services described herein.</i></p> <p>_____ Signature</p> <p>_____ Date</p>
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