

EYE CARE GROUP CLAIM FORM

Group Claim Office / P.O. Box 82510, Lincoln, NE 68501
Toll Free No.: 800-497-7044 / Fax: 402-467-7336

RELIANCE STANDARD
Life Insurance Company

a DELPHI company

PLEASE BE AS COMPLETE AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS CLAIM FORM.
ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

PART A - TO BE COMPLETED BY INSURED

1. PATIENT'S NAME (Last, First, Middle)	2. PATIENT'S BIRTHDATE	3. PATIENT'S SEX ☐ M ☐ F	4. RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other
5. INSURED'S NAME (Last, First, Middle)	6. INSURED'S SOCIAL SECURITY NO.	7. INSURED'S BIRTHDATE	
8. INSURED'S STREET ADDRESS		9. NAME OF EMPLOYER / GROUP NUMBER 136-413210	
10. CITY, STATE, ZIP CODE			

11. IS PATIENT COVERED FOR EYE CARE BY ANOTHER PLAN? ☐ Yes ☐ No If YES, please complete boxes 12 through 16.		12. NAME AND ADDRESS OF OTHER CARRIER	
13. INSURED'S NAME	14. RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other	15. INSURED'S BIRTHDATE	16. INSURED'S SSN / GROUP NUMBER

17. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER.

Is patient a full-time student? ☐ Yes ☐ No. If YES, Name and Address of School _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO RELIANCE STANDARD ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT.

SIGNATURE _____
OF INSURED _____ DATE _____

It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and/or civil penalties can result from such acts.

PART B - TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME (Last, First, Middle)		2. TITLE ☐ D.O. ☐ M.D. ☐ O.D.	
3. DOCTOR'S STREET ADDRESS		4. CITY, STATE, ZIP CODE	
5. PHONE ()	6. WERE EYEGLASSES PRESCRIBED? ☐ YES ☐ NO WERE CONTACTS PRESCRIBED? ☐ YES ☐ NO	7. HAS CATARACT SURGERY BEEN PERFORMED? ☐ YES ☐ NO	8. EXAMINATION DATE PLEASE ENTER EXAMINATION CHARGE IN FEE COLUMN BELOW (BLOCK 12.)
9. ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Doctor's Tax I.D. # _____		10. I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON. DOCTOR'S SIGNATURE _____ DATE _____	

11. DIAGNOSIS OR NATURE OF OFFICE VISIT

PART C - TO BE COMPLETED BY DOCTOR/DISPENSER

CHECK APPROPRIATE BOX

FRAME	SIZE & MODEL						MFG.		ZYL	METAL	RIMLESS	COMBO
LENSES	# OF LENSES	GLASS	PLASTIC	SV	BIF	TRI	PAL	SAFETY	OTHER			
LENS OPTIONS	OS	TINT	GRAD	DBL GRAD	COAT	UV400	FACET	PHOTO CHROMIC	OTHER			
CONTACT LENSES	# OF LENSES	HCL	SCL	HGP	DISPOS-ABLE	SPH	BIF	TORIC	EW	TINT	NUMBER REPLACED	OTHER
DATE ORDERED				DATE DISPENSED				OTHER SERVICES				
DISPENSING OFFICE										PHONE ()		
ADDRESS		STREET			CITY			STATE		ZIP		
ASSIGNMENT CANNOT BE MADE WITHOUT TAX I.D. NUMBER. Dispensers Tax I.D. Number _____												
I HEREBY CERTIFY THAT I HAVE PERFORMED THE SERVICES AS INDICATED HEREON.												
DISPENSER'S SIGNATURE _____										DATE _____		

12. EXAMINATION CHARGE	AMOUNT
FRAME CHARGE	
LENS CHARGE	
OPTIONS CHARGE	
CONTACT CHARGE	
OTHER SERVICES	
SUBTOTAL	
SALES TAX (If Applicable)	
TOTAL CHARGES	
AMOUNT PAID BY PATIENT	