Professional Benefits Services Inc.
2959 Lucerne, SE, Suite 205
Grand Rapids, Michigan 49546

Telephone:
1-616-285-2480

OPTICAL/VISION CLAIM NOTICE

1. Employee/Member must complete section below.
2. One claim form to be submitted for each payment.
3. Examiner or Dispenser fills out their section and mails to administrator.

TO BE COMPLETED BY EMPLOYEE - SECTION 1

Employee (Full Name):	Sex ☐M ☐F	Date of Birth:	Social Security Number:
Address, Street Name:	Patient's Full Name:		Sex ☐M ☐F
City, State, Zip:	Date of Birth:	Patient's Marital Status & Relationship to Employee: ☐Single ☐Married ☐Divorced ☐Sep. ☐Emp. ☐Spouse ☐Child	
Employer:	Group Plan Number:		
Does patient have other health coverage? ☐ Yes ☐ No If Yes, please identify:	Or group vision plan? ☐ Yes ☐ No If Yes, please identify:		
Reason for claim: ☐ Change in prescription ☐ Other (give reason):			
Was treatment required due to accidental injury? ☐ Yes ☐ No	When did accident happen? Date	Where? Place:	

REIMBURSEMENT: I agree to reimburse the PLAN for any overpayments which are in excess of what the PLAN allows. I further agree to reimburse the PLAN, all benefits paid to me or on my behalf, should I recover any money for the same accident or illness for which benefits were paid. This agreement applies to all recoveries, including benefits paid or recovered under any State or Federal Workers Compensation Statute, whether by redemption, voluntary payment, compromise, settlement, court order or any other form.

INFORMATION AUTHORIZATION: **I hereby authorize my employer or PBS to release or obtain any information necessary to determine benefits under this Plan. A photocopy of this release will carry the same authority as the original.**

PAYMENTS: Payments will be made directly to providers unless bills are clearly marked as paid or accompanied by a PAID receipt.

Signature of Employee or Member:	Signature of Spouse (if applicable)
X_____	X_____

EXAMINATION ONLY (If applicable) - SECTION 2

TO BE COMPLETED BY PHYSICIAN

Name (Full Name):

Address, Street Name:

City, State, Zip

Show Specialty	Social Security # or Tax Info. # *(Required by Law)*	Phone Number:

I hereby certify that services listed have been performed on the named patient on the date indicated and that the fees shown are those currently charged to the majority of my patients.

Date: Signature of Examiner:

X_____

EXAMINATION RECORD

DESCRIPTION OF SERVICES (Including Exams, Tests, Other)	DATE PERFORMED	FEE
PAID BY PATIENT? ☐ Yes ☐ No	TOTAL	

IF EYEWEAR IS PRESCRIBED - SECTION 3

TO BE COMPLETED BY DISPENSER/PHYSICIAN

Name (Full Name):

Address, Street Name:

City, State, Zip

Show Specialty	Social Security # or Tax Info.# *(Required by Law)*	Phone Number:

I hereby certify that services listed have been performed on the named patient on the date indicated and that the fees shown are those currently charged to the majority of my patients.

Date: Signature of Examiner:

X_____

TREATMENT RECORD

Is this claim due to a prescription change of the eye? ☐ YES ☐ NO

Are glasses/lenses required by employer as a condition of employment? ☐ YES ☐ NO

Is this a duplicate prescription? If Yes, date of prior dispensing: ☐ YES ☐ NO

If replacement frames are dispensed, provide date of previous purchase:

DESCRIPTION OF SERVICES (Including glasses, lenses, frames)	DATE SERVICE PERFORMED MO.	DAY	YR.	FEE
SINGLE CORRECTIVE LENSES				
BI-FOCAL LENSES				
TRI-FOCAL LENSES				
CONTACTS ☐ Hard ☐ Soft				
FRAMES				
MISC. CHARGES				
PAID BY PATIENT? ☐ Yes ☐ No	TOTAL			