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