VISION CARE
BENEFIT REQUEST FORM

EMPLOYEE PLANS, LLC
P O BOX 2362
FT. WAYNE, IN 46801-2362

www.employeeplansllc.com
Ph: 260-625-7500
Fax: 260-625-7530

THIS SECTION TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE PORTION

Employee's Name (first, middle initial, last)		Social Security Number	Employee Date of Birth
Employee's Home Address		Employer's Name	Group No (See ID Card)
Patient's Name (other than employee)	Relationship	Patient Date of Birth	Patient Sex ☐ Male ☐ Female

If dependent is a child over age 18 – Complete the following: Please send proof of class registration for each semester
Full Time Student? ☐ Yes ☐ No

Are any of your dependents presently employed? ☐ Yes ☐ No If yes, identify who is employed and the name and address of the employer.

Are you and your dependents entitled to benefits for these same expenses under any other insurance plan? ☐ Yes ☐ No

If Yes, from whom?

Was an accident involved?	If yes, when and where did the accident happen?	Did the accident happen at work?
☐ Yes ☐ No	Date	☐ Yes ☐ No

I hereby authorize any Insurance Company, Organization, Employer, Ophthalmologist, Optometrist, and Optician to release any information with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct.

Signature of Employee	Date	**Pay Provider?**
Also, signature of Dependent (if Patient, and not a Minor)	Date	☐ Yes ☐ No

THIS SECTION TO BE COMPLETED BY PROVIDER

PLEASE COMPLETE TWO SEPARATE FORMS IF EXAM AND MATERIALS ARE BILLED BY DIFFERENT PROVIDERS

EXAMINATION

Patient's Name _____ Age _____

Indicate the nature of Disease, Injury or Vision Disorder .....

Date of Exam	Refraction	Tonometry	Contact Lenses	Cataract Surgery	Initial Prescription
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Does patient require a prescription change at this time? ☐ Yes ☐ No
Must be completed if there was a prior prescription
Axis change _____ degrees. Sphere or cylinder change _____ diopters.

Do lenses improve Visual Acuity by at least one line on the standard chart? ☐ Yes ☐ No

$ _____ EXAMINATION CHARGE

$ _____ AMOUNT PAID BY EMPLOYEE

LENSES

Date Ordered	Date Dispensed		Sphere	Cylinder	Axis	Prism	Add
		OD					
		OS					

Materials Supplied ☐ PLASTIC ☐ GLASS

☐ Pair ☐ ½ Pair

Seg Style/Width ☐ Executive ☐ Flattop ☐ Kryptok ☐ Panoptic ☐ Round ☐ _____

TYPE LENS:

	CHARGE
☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Lenticular	
☐ Contact Lenses	$ .....
☐ Oversized Lenses	$ .....
☐ Sunglasses	$ .....
☐ Tint # _____% of light transmittance	$ .....
☐ Photosensitive – i e Brown, Gray, etc	$ .....
☐ Other (please explain)	$ .....
Lens Mfr.	.....
TOTAL LENS CHARGE	.....

FRAMES

Date Ordered	Date Dispensed	Parts ☐ Complete ☐ Partial	Composition ☐ ZYL ☐ Metal ☐ ZYL Comb.
Frame Mfr.	Frame Name		

Comments _____

FRAME CHARGE $ .....

AMOUNT PAID BY EMPLOYEE $ ..... $ .....

Name of Provider who performed the services (print) Phone (Include Area Code)

Address: Street City State Zip Code

Signature Degree/Title SS #: Employer ID #

Date 20

▲ Must be Furnished Under Authority of Law ▲

EPI-4
9/03