VISION CARE CLAIM FORM

QUALITY PLAN ADMINISTRATORS, INC.,
Terra Nova Building
7824 Eastern Avenue, N.W.
Suite 100
Washington, D.C. 20012

☐ Participating Provider
☐ Non-Participating Provider

Certification #

Date Received

PART A – EMPLOYEE/PATIENT INFORMATION (TO BE COMPLETED BY EMPLOYEE

1. Patient Name (First Name, Middle Initial, Last Name)
2. Relationship To Employee
3. Sex M F
4. Patient Birthdate MO DAY YR

5. Employee's Name (First Name, Middle Initial, Last Name)
6. Employee Social Security Number / /
7. Home Phone Number / Work Number

8. Employee Mailing Address, City, State, Zip Code
9. If patient is full-time student give Name of school ______ Date of Present Term From ______ To ______

10. Control No.
11. Employee's Employer
12. Were these services required due to a work related injury or condition? ☐ Yes ☐ No

13. SIGNED: *I Authorize the Release of any Information Necessary to Process this request. I certify the information furnished by me in support of this request is true and correct.*

______ (SIGNATURE OF EMPLOYEE) ______ (DATE)

______ (SIGNATURE OF PATIENT, OR PARENT IF MINOR) ______ (DATE)

14. Is this exam or glasses covered under a company safety glass program? ☐ Yes ☐ No
If Yes, indicate which ☐ exam ☐ lenses ☐ frames
Are you or your dependents entitled to benefits under any other insurance plan? Yes ______ No ______ If yes, from whom.

PART B – EXAMINING PHYSICIAN OR OPTOMETRIST INFORMATION

15. Indicate Diagnosis or Nature of Disease or Injury or Vision Disorder.
If contact lenses prescribed, indicate:
____ Cosmetic ____ Visual acuity is not correctable with ophthalmic lens to 20/70 in better eye

16.		SPHERE	CYLINDER	AXIS	PRISM	ADD BIFOCAL	ADD TRIFOCAL	VISUAL ACUITY DIST.	VISUAL ACUITY READING
PRESCRIPTION	R								
	L								

17. Was lens change required? ☐ Yes ☐ No If yes, do new lenses differ from the most recent prescription (or in absence of a previous prescription (by an axis change of 20 degrees or .50 diopter sphere change or .50 diopter cylinder change and do lenses improve visual acuity by at least one line on standard chart?
☐ Yes ☐ No

18. Report of service (or attach itemized bill)

DATE OF SERVICE	SERVICE RENDERED	
	☐ Exam	☐ Glaucoma

19. Provider's Name, Address, City, State, Zip Code ☐ Ophthalmologist ☐ Optometrist
20. Telephone No.
21. Total Charge Exam only
22. Enter the Taxpayer Identification Number to be used for 1099 Reporting Purposes
23. Amount Paid
24. ______ SIGNATURE OF PHYSICIAN OR OPTOMETRIST
25. Date Signed
26. Balance Due

PART C – SUPPLIER INFORMATION (TO BE COMPLETED BY DISPENSER OF PRESCRIPTION)

27. LENSES ☐ One Eye ☐ Both Eyes ☐ Glass ☐ Plastic ☐ Other

Date Material Ordered ______
Date Delivered ______

Charges: Single Vision $______ Bifocal $______ Trifocal $______
Lenticular $______ Contact lenses $______ Other $______
$______

28. Describe and indicate additional charges for special features such as:
☐ Tinting (more than tint #1 and #2) $______ ☐ Aphakic $______ ☐ Oversized lenses $______ ☐ Progressive lenses $______
☐ OTHER (Specify)

29-a. FRAMES
☐ From Pre-Approved Selection –$20
☐ Not from Pre-Approved Selection
(If "Not from Pre-Approved Selection" fill out 29-b.)

29-b. FRAMES
$______ Cost
$20.00 ______ Less Plan Frame Allowance
$______ Patient Co-Payment

30. Charge for lenses
31. Charge for frame
32. Total Charge

33. Signature of Supplier ______
34. Date Signed ______
35. Amount Paid
36. Balance Due

TO All Vision Providers

TOPIC: **Prompt Reimbursement**

TO ENSURE CLAIMS ARE PROCESSED IN A TIMELY MANNER BY QPAI, AND TO ASSURE YOUR PROMPT PAYMENT, PLEASE MAKE SURE TO ADHERE TO THE FOLLOWING GUIDELINES.

A) Claims must be submitted within 180 days of service, or they will be denied.

B) Claim form is filled out completely, ie. Date of Service, applicable procedures and codes, Providers Signature, etc.

C) All appeals must be filed, in writing, within 60 days of notification to you.

D) All claims must be filed for services rendered for actuarial purposes. (whether payable by QPAI or the patient)

Please send all completed claim forms to:

Quality Plan Administrators, Inc.

QUALITY PLAN ADMINISTRATORS, INC.,
Terra Nova Building
7824 Eastern Avenue, N.W.
Suite 100
Washington, D.C. 20012