STATEMENT OF VISION CARE (Examinations and Materials)

PART A – TO BE COMPLETED BY EMPLOYEE

1. PATIENT'S NAME *(First name, middle initial, last name)*
2. PATIENT'S DATE OF BIRTH
3. EMPLOYEE'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(If different from employee)*
5. PATIENT'S SEX MALE ☐ ☐ FEMALE
6. EMPLOYEE ADDRESS IS THIS A NEW ADDRESS? ☐ YES ☐ NO

CITY STATE ZIP PHONE NO.

7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

CITY STATE ZIP

FULL TIME STUDENT? ☐ YES ☐ NO IF YES, WHERE?

9. EMPLOYEE'S EMPLOYER

8. EMPLOYEE'S SOC. SEC. NO. ☐☐☐ – ☐☐ – ☐☐☐☐

10 EMPLOYEE'S DATE OF BIRTH

11. ☐ ACTIVE ☐ RETIRED EFF. DATE OF RETIREMENT

12. ANY OTHER VISION BENEFITS FOR EMPLOYEE, SPOUSE OR PATIENT? (CHECK ONE OF THE FOLLOWING) ☐ YES ☐ NO
WHO? ☐ SELF ☐ SPOUSE ☐ DEPENDENT, IF DEPENDENT OR SPOUSE FULL NAME ______ DATE OF BIRTH ______
COVERAGE PROVIDED THROUGH ☐ BLUE CROSS/BLUE SHIELD ☐ EMPLOYER SPONSORED PLAN ☐ COMMERCIAL INSURANCE COMPANY ☐ HEALTH MAINTENANCE ORGANIZATION (HMO) ☐ MEDICAID ☐ OTHER
GIVE NAME AND ADDRESS OF OTHER COVERAGE ABOVE ______

13. IS SPOUSE EMPLOYED? ☐ YES ☐ NO
SPOUSE'S NAME IF YES SOC. SEC. NO.

14. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT YES ☐ ☐ NO
B. AN ACCIDENT YES ☐ ☐ NO

15. IF AN ACCIDENT
date ______ 19 ____ and time ______ ☐ A.M. ☐ P.M.
description (how & when) ______

16. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.

17. To all physicians and other health professionals and all hospitals and other health care instututions:

You are authorized to provide Aultcare information concerning health care, advice, treatment or supplies provided the Patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits.

Aultcare may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.

This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted.
I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Date: ______ Patient's or Authorized Person's Signature ______

18. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DOCTOR AND OR DISPENSER OF VISION CARE FOR THE SERVICES DESCRIBED BELOW.

SIGNED (EMPLOYEE OR AUTHORIZED PERSON) ______ DATE ______

PART B – TO BE COMPLETED BY DOCTOR

1. DOCTOR'S NAME (Last, First, Middle)
2. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER.
3. DOCTOR'S ADDRESS (No., Street, City, State, Zip)
4. PHONE NO. *(Area Code)* ( )
5. TITLE M.D. ☐ D.O. ☐ O.D.
6. EXAMINATION DATE(S)
7. HAS CATARACT SURGERY BEEN PERFORMED ☐ Yes ☐ No
8. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSES? ☐ Yes ☐ No
9. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? ☐ Yes ☐ No
10. DIAGNOSTIC CODE(S) ______ ; ______ ; ______ ; ______
11. INDICATE DIAGNOSIS OR NATURE OF DISEASE OR INJURY OR VISION DISORDER, INDICATE PROCEDURE CODE #'S
12. VISUAL ACUITY CORRECTED TO:

PROFESSIONAL SERVICES	AMOUNT
EXAMINATION CHARGE	
SALES TAX (If any)	
TOTAL	
AMOUNT PAID BY PATIENT	

13. DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
R.E.	•	•			
L.E.	•	•			
READING ADD	R.E.	+ •	L.E.	+ •	

14. I hereby certify that I have performed the services as indicated hereon.

DOCTOR'S SIGNATURE DATE

PART C – TO BE COMPLETED BY DISPENSER

IN LIEU OF DISPENSER COMPLETING THIS SECTION A LABORATORY BILL CAN BE ATTACHED. DISPENSER MUST SIGN THIS FORM, ENTER AMT. P.D. BY PATIENT

1. DISPENER'S NAME (Last, First, Middle)
2. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER.
3. DISPENSER'S ADDRESS (No., Street, City, State, Zip)
4. PHONE NO. *(& Area Code)* ( )
5. DISPENSER'S TITLE ☐ Ophthalmologist ☐ Optician ☐ Optometrist
6. MATERIALS SUPPLIED Tint # ______ ☐ Oversized ☐ Pair ☐ Glass ☐ ½ Pair ☐ Plastic ☐ Other ______
7. DATE ORDER DELIVERY
8. TYPE OF LENSES DISPENSED
☐ None ☐ Single ☐ Bifocal ☐ Trifocal ☐ Lenticular ☐ Contacts ☐ Sunglasses ☐ Other *(Specify)* ______
9. CONTACT LENSES *(If Contact Lenses, Please Complete)*
☐ Therapeutic ☐ Non-Therapeutic ☐ Hard Lenses ☐ Soft Lenses
10. FRAME MODEL OR CAT. NO. & SIZE
11. FRAME MFT. NAME
12. I hereby certify that I have performed the services as indicated hereon.

DISPENSER'S SIGNATURE DATE

PROFESSIONAL SERVICES		AMOUNT
LENS CHARGE		
FRAME CHARGE		
OPT	LENS	
	FRM	
DISP. FEE	LENS	
	FRM	
SALES TAX (If any)		
TOTAL		
AMOUNT PAID BY PATIENT		

Form 1213 D: 12/90 **Reviewed 8/27/2015**

STATEMENT OF CLAIM FOR VISION CARE BENEFITS

Aultcare
P.O. Box 6910
Canton, Ohio 44706-0910

Instructions For Filing a Vision Claim

EMPLOYEE

COMPLETE THE "PATIENT INFORMATION" (PART A — ITEMS 1 THROUGH 18) ON THE REVERSE SIDE OF THIS FORM.

If you wish your benefits paid directly to your Doctor or Optometrist, sign item 18. If you wish benefits paid directly to the provider of materials, sign item 18. A separate form should be submitted for each family member.

Please be sure you have provided the employee's Social Security Number.

SEND THE COMPLETED "BENEFIT REQUEST FORM" DIRECTLY TO THE AULTCARE OFFICE LISTED ABOVE.

DOCTOR OR OPTOMETRIST

PLEASE COMPLETE PART B OF THE REVERSE SIDE OF THIS FORM (EXAMINING DOCTOR OR OPTOMETRIST INFORMATION) AND SIGN YOUR NAME. PLEASE RETURN THE COMPLETED FORM TO YOUR PATIENT.

DISPENSER OF MATERIAL

PLEASE COMPLETE PART C OF THE REVERSE SIDE OF THIS FORM (SUPPLIER INFORMATION) AND RETURN THE COMPLETED FORM TO THE PATIENT.

Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

AultCare/Aultra General Tag Lines for the State of Ohio

English
If you, or someone you are helping, have questions about **AultCare/Aultra** you have the right to get help and information in your language at no cost. To speak with an interpreter, call **Local: 330.363.6360 Outside Stark County: 1.800.344.8858 TTY Local: 330.363.2393 Outside Stark County: 1.866.633.4752**

Spanish
Español
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca **AultCare/Aultra** tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al **Local : 330.363.6360 Fuera del condado de Stark : 1.800.344.8858 TTY Local : 330.363.2393 Fuera del condado de Stark : 1.866.633.4752**

Chinese
中文
如果您，或是您正在協助的對象，有關於 **AultCare/Aultra 保險公司** 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 本地： **330.363.6360 斯塔克縣外： 1.800.344.8858 TTY 線 本地： 330.363.2393 斯塔克縣外： 1.866.633.4752。**

German
Deutsche
Falls Sie oder jemand, dem Sie helfen, Fragen zum **AultCare/Aultra** haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752** an.

Arabic
ال عرب ية
العربية، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب
AultCare/Aultra إن كان لديك أو لدى شخص تساعده أسئلة بخصوص شركة التأمين
خارج مقاطعة ستارك . 1.866.633.4752 المحلي: 330.363.2393 الخط **TTY** خارج مقاطعة ستارك : 1.800.344.8858

Pennsylvania Dutch
Deitsch
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut **AultCare/Aultra** hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du **Local: 330.363.6360 Außerhalb von Stark County: 1.800.344.8858 TTY –Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752** uffrufe.

Russian
русский
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу **Страховая компания AultCare/Aultra**, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону **Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 330.363.2393 Вне Старка County : 1.866.633.4752.**

French
Français
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de **Compagnie d'Assurance AultCare/Aultra**, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, **Appelez Locale 330.363.6360 En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local : 330.363.2393 En dehors du comté de Stark : 1.866.633.4752**.

Vietnamese
Việt Nam
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về **Công ty Bảo hiểm AultCare/Aultra** quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi **Địa phương: 330.363.6360 Bên ngoài của Stark County : 1.800.344.8858 TTY đường dây Địa phương: 330.363.2393 Bên ngoài của Stark County : 1.866.633.4752.**

Cushite-Oromo
Isin yookan namni biraa isin deeggartan **AultCare/Aultra,** irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa **Local: 330.363.6360 Outside of Stark County: 1.800.344.8858 TTY Line Local: 330.363.2393 Outside of Stark County: 1.866.633.4752** tiin bilbilaa.

Korean
한국어
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 **AultCare/Aultra 보험 회사** 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 **지역 : 330.363.6360 스타크 카운티 의 외부 : 1.800.344.8858 TTY 라인 지역 : 330.363.2393 스타크 카운티 의 외부 : 1.866.633.4752**
로 전화하십시오.

Italian
Italiano
Se tu o qualcuno che stai aiutando avete domande su **AultCare/Aultra**, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare **Locale: 330.363.6360 Al di fuori di Stark County : 1.800.344.8858 TTY linea Locale: 330.363.2393 Al di fuori di Stark County : 1.866.633.4752.**

Japanese
日本語
ご本人様、またはお客様の身の回りの方でも **AultCare/Aultra 保険会社**についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、
ローカル： **330.363.6360 スターク郡の外： 1.800.344.8858 TTY ライン ローカル： 330.363.2393 スターク郡の外：**
1.866.633.4752 までお電話ください。

Dutch
Nederlands
Als u, of iemand die u helpt, vragen heeft over **AultCare/Aultra,** heeft u het recht om hulp en informatie te krijgen in uw taal zonder kosten. Om te praten met een tolk, bel **Local : 330.363.6360 Buiten Stark County : 1.800.344.8858 TTY Line Local : 330.363.2393 Buiten Stark County : 1.866.633.4752.**

Ukrainian
український
Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про **Страхова компанія AultCare/Aultra,** у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на **Місцевий : 330.363.6360 Поза Старка County : 1.800.344.8858 TTY лінія Місцевий : 330.363.2393 Поза Старка County : 1.866.633.4752.**

Romanian
Română
Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind **Compania de Asigurari AultCare/Aultra**, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la **Locale : 330.363.6360 In afara Stark Judet : 1.800.344.8858 TTY linie Locale : 330.363.2393 In afara Stark Judet : 1.866.633.4752.**

Non-Discrimination Notice:

AultCare/Aultra complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AultCare/Aultra does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AultCare/Aultra provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). AultCare/Aultra provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, or if you believe that AultCare/Aultra has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact or file a grievance with the: AultCare/Aultra Civil Rights Coordinator, 2600 6th St. S.W. Canton, OH 44710, 330-363-7456, CivilRightsCoordinator@aultcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.