AULTCARE

STATEMENT OF VISION CARE
(Examinations and Materials)

PART A
THIS INFORMATION IS TO BE COMPLETED BY THE EMPLOYEE

PATIENT NAME
First Name | Middle | Last

Street | City | State | Zip Code

Gender ☐ Male ☐ Female | Date of Birth

EMPLOYEE NAME
First Name | Middle | Last

Social Security Number | Date of Birth

Address (if different from patient)
Street | City | State | Zip Code

Employer | Work Status ☐ Active ☐ Retired | Effective date of retirement

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Full-time student? ☐ Yes ☐ No If yes, where? _____

Are there any other vision benefits for the: ☐ employee ☐ spouse ☐ patient

If dependent or spouse, please denote full name | Date of Birth

Other coverage is provided through:
☐ Blue Cross/Blue Shield ☐ Employer Sponsored Plan ☐ Commercial Insurance Company
☐ Health Maintenance Organization (HMO) ☐ Medicaid ☐ Other

Please provide information of the other coverage denoted above:
Name | Street | City | State | Zip Code

Is the spouse employed? ☐ Yes ☐ No If yes, Spouse's Name | Social Security Number

If yes, name and address of spouse's employer:
Name | Street | City | State | Zip Code

Was the condition related to the patient's employment? ☐ Yes ☐ No
Was the condition related to an accident? ☐ Yes ☐ No

If the condition was related to an accident: Date | Time

Description (how and when) _____

To all physicians, other health professionals, all hospitals, and other healthcare institutions: You are authorized to provide AultCare information concerning healthcare, advice, treatment, or supplies provided to 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 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.

Patient or Authorized Person Signature _____ Date _____

I hereby authorize payment directly to the named doctor and/or dispenser of vision care for the services described on the next page.

Employee or Authorized Person Signature _____ Date _____

PART B
THIS INFORMATION IS TO BE COMPLETED BY THE DOCTOR

DOCTOR'S NAME Last	First	Middle	Title ☐M.D. ☐D.O. ☐O.D.

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. _____

Street	City	State	Zip Code
Phone Number	Examination Date(s)		

Has cataract surgery been performed? ☐Yes ☐No
Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses? ☐Yes ☐No
Does the patient require a prescription change at this time? ☐Yes ☐No

Diagnostic Code(s)							

Indicate diagnosis, nature of disease, injury, or vision disorder _____

_____

Indicate the procedure code numbers	Visual acuity corrected to

Doctor's Prescription

Sphere		Cylinder	Axis	Prism	Base
R.E.	•	•			
L.E.	•	•			
Reading Add		R.E.	+•	I.E.	+•

Professional Services	Amount
Examination Charge	
Sales Tax (if any)	
Total	
Amount Paid by Patient	

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

Doctor's Signature _____ Date _____

In lieu of dispenser completing this section, a laboratory bill can be attached. Dispenser must sign this form and enter amount paid by patient.

PART C
THIS INFORMATION IS TO BE COMPLETED BY DISPENSER

DISPENSER'S NAME Last	First	Middle

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. _____

Street	City	State	Zip Code
Phone Number	Title: ☐Optician ☐Ophthalmologist ☐Optometrist		

Materials Supplied
Tint # _____ ☐Oversized ☐Pair ☐Glass ☐½ Pair ☐Plastic ☐Other _____

Order Date	Delivery Date

Type of lenses dispensed:
☐None ☐Single ☐Bifocal ☐Trifocal ☐Lenticular ☐Contacts
☐Sunglasses ☐Other (specify)_____

Contact Lenses (If contact lenses, please complete.)
☐Therapeutic ☐Non-Therapeutic ☐Hard Lenses ☐Soft Lenses

Frame Model or Cat. No. & Size	Frame MFT. Name

I hereby certify 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		

AULTCARE

INSTRUCTIONS FOR FILING A VISION CLAIM

EMPLOYEE

Complete the Patient Information section. (Part A)

If you wish your benefits are paid directly to your Doctor or Optometrist, sign the bottom of Part A page. If you wish your benefits are paid directly to the provider of materials, sign the bottom of Part A page. 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 AultCare at either PO Box 6910 Canton, OH 44706, via fax at 330-470-4757, or via email at ancillaryclaimsservices@aultcare.com.

DOCTOR OR OPTOMETRIST

Please complete Part B 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 this form (supplier information) and return the completed form to the patient.

INSURANCE FRAUD WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I acknowledge that AultCare may use and disclose my protected health information, as well as, the protected health information of my family for payment, treatment, and operations. This information may be disclosed to other insurance companies, third party administrators, state and federal agencies, health care providers and other organizations and persons that perform professional, business, or insurance functions for AultCare, as permitted by state and federal law. The information may be used for, but not limited to, processing enrollment applications, risk classifications, detecting or preventing fraud, internal and external audits, claims administration, case management, quality improvement programs, public health reporting, law enforcement investigations, coordination of benefits, medical management programs, and subrogation.