



**INSTRUCTIONS FOR FILING YOUR CLAIM:**

1. COMPLETE PART A BELOW.
2. SIGN AUTHORIZATION ON BACK OF FORM IF YOU WISH PAYMENT TO BE MADE DIRECTLY TO THE PROVIDER.
3. HAVE YOUR PROVIDER COMPLETE PART B ON BACK OF FORM AND RETURN TO YOU.
4. ATTACH ANY ADDITIONAL VISION BILLS.

**PART A**

**EMPLOYEE'S STATEMENT OF CLAIM FOR GROUP VISION INSURANCE BENEFITS**

I HEREBY PRESENT THIS CLAIM, AND AUTHORIZE ANY INDIVIDUAL OR ORGANIZATION TO RELEASE INFORMATION REQUIRED FOR ITS ACCEPTANCE.

1. CLAIM IS BEING MADE FOR: <input type="checkbox"/> Self <input type="checkbox"/> Unmarried child. If age 19 or over, insurance continued as <input type="checkbox"/> Full time student attending _____ <input type="checkbox"/> Wife/Husband <input type="checkbox"/> Other (Specify) _____			
2. PATIENT'S NAME		DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
3. IS THIS CLAIM THE RESULT OF A WORK RELATED ILLNESS OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
4. ARE YOU (EMPLOYEE) MARRIED?  <input type="checkbox"/> YES <input type="checkbox"/> NO	4a. IS YOUR WIFE/HUSBAND EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO _____ Employer Name _____ Employer Address _____ Spouse SS#		4b. IF CLAIM IS FOR A DEPENDENT CHILD, IS THIS CHILD EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO _____ Employer Name _____ Employer Address _____ Spouse SS#
	5. IS PATIENT ALSO COVERED FOR ANY OTHER INSURANCE BENEFITS AS LISTED BELOW, EITHER AS AN EMPLOYEE OR DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, check box below which applies and complete 5a. <input type="checkbox"/> Group health insurance of any kind including Blue Cross and Blue Shield. <input type="checkbox"/> Coverage of vision care expenses provided by an employer, a union welfare plan, any federal, state, provincial or other governmental program <input type="checkbox"/> Other arrangement of benefits for individuals or a group.		5a. GIVE NAME AND ADDRESS OF OTHER COMPANY OR ORGANIZATION PROVIDING INSURANCE: _____ Name _____ Address _____ Other insurance or Blue Cross/Blue Shield Group No.(s)
6. EMPLOYER'S/COMPANY'S NAME		GROUP NUMBER	EMPLOYER'S ADDRESS
7. EMPLOYEE'S NAME (PRINT OR TYPE)		SOCIAL SECURITY NUMBER	DATE OF BIRTH
STREET NO.		CITY	STATE    ZIP CODE

**SEND CLAIM TO: EBSO, Inc. ; P.O. BOX 928; FINDLAY, OH 45839**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**PART B**

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the undersigned Provider of Vision Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for this services.	SIGNED (INSURED PERSON) _____ _____ align="right">DATE
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**TO BE COMPLETED BY THE DOCTOR OR PROVIDER OF SERVICE**

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH
DIAGNOSIS AND CONCURRENT CONDITIONS	

**REPORT OF SERVICES (OR ATTACH ITEMIZED BILL)**

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SERVICES RENDERED	CHARGES
		EXAMINATION	
		LENSES:	
		SINGLE <input type="checkbox"/> ONE <input type="checkbox"/> TWO	
		BIFOCAL <input type="checkbox"/> ONE <input type="checkbox"/> TWO	
		TRIFOCAL <input type="checkbox"/> ONE <input type="checkbox"/> TWO	
		LENTICULAR <input type="checkbox"/> ONE <input type="checkbox"/> TWO	
		CONTACTS* <input type="checkbox"/> ONE <input type="checkbox"/> TWO	
		FRAMES	

+O - Doctor's Office      IH - Inpatient Hospital      NH - Nursing Home H - Patient's Home      OH - Outpatient Hospital      OL - Other Locations	TOTAL CHARGES \$ _____ AMOUNT PAID \$ _____ BALANCE DUE \$ _____
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IS THIS IS A REPLACEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE GIVE REASON FOR REPLACEMENT: _____ _____ _____	*FOR CONTACT LENSES: MEDICALLY NECESSARY <input type="checkbox"/> YES <input type="checkbox"/> NO COSMETIC <input type="checkbox"/> YES <input type="checkbox"/> NO VISUAL ACUIITY            _____ OD            _____ OS
DATE: _____      DEGREE: _____	INDIVIDUAL PRACTITIONER SOCIAL SECURITY NUMBER _____ ALL OTHERS - EMPLOYER ID NUMBER _____
PHYSICIAN/SUPPLIER NAME: _____      TELEPHONE NUMBER: _____	_____ MUST BE FURNISHED UNDER AUTHORITY OF LAW
PHYSICIAN'S SIGNATURE: _____	
STREET ADDRESS: _____      CITY OR TOWN: _____      STATE: _____      ZIP CODE: _____	