

eye care

group claim form

Group Claim Office
 P.O. Box 82520 / Lincoln, NE 68501-2520
 Toll Free 800.487.5553 / Fax 402.467.7336
 Web ameritasgroup.com/stateSD
 Ameritas' payer ID for electronic claims is 47009.



PART 1 – TO BE COMPLETED BY MEMBER

1. Patient's full name (first, middle initial, last)		2. Patient birthdate (MM/DD/YY)		3. Relationship to member <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other		4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
5. Member's full name (first, middle initial, last)		6. Member's State ID number		Member's birthdate (MM/DD/YY)			
7. Member's mailing address (Street address or P.O. Box, City, State, ZIP)				Email address			
8. Employer (company) name and address State of South Dakota						9. Group number 010-350730	

QUESTIONS 10 AND 11 MUST BE COMPLETED WITH EACH CLAIM SUBMISSION

10. Is patient covered by another eye care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and address of other carrier		Policy number		Name and address of other employer	
11. Other member/subscriber name		Member/subscriber identification number		Date of birth (MM/DD/YY)		Relationship to patient	
12. I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of treatment. I certify these statements to be true and complete to the best of my knowledge.				13. I hereby authorize payment directly to the below named provider of group insurance benefits otherwise payable to me.			

X _____ Date _____
 Signature (patient, or parent if minor)

X _____ Date _____
 Signature (insured person)

Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim are provided by the claimant.

PART 2 – TO BE COMPLETED BY ATTENDING EYE CARE PROVIDER.

14. Eye care provider name and mailing address		For Yes answers to questions 16-18, enter a brief description and date.					
Specialty		Phone number		16. Is treatment result of occupational illness or injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Email		Fax number		17. Is treatment result of auto accident?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Federal tax ID number <input type="checkbox"/> SSN <input type="checkbox"/> TIN		NPI (National Provider Identifier)		18. Other accident?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
License #				19. This is a (please check one): <input type="checkbox"/> Statement of actual services <input type="checkbox"/> Pretreatment estimate			
				20. Is this for LASIK/PRK?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

21. EXAMINATION AND TREATMENT RECORD Please include date of service, description of services, procedure code and fee.

Date service performed (MM/DD/YY)	Description of services	CPT/HCPCS procedure code	Diagnosis code	LASIK PRK	Left eye	Right eye	Fee

22. Remarks							23. Total \$
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24. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.			25. Address where treatment was performed				
X _____ Date _____ Signature (Provider)							

tips

how to speed claims processing

part 1 – employee

Missing or incomplete information will slow down claims processing. To avoid this, please be sure to include:

#2 Patient birthdate

Helps identify an insured and determine dependent eligibility.

#6 Employee's identification number

This is the most important identifier for the plan member.

#8 Student status

Because this information often changes, it is required on every claim for dependents age 19 years and older.

#11 and **#12** Coordination of benefits

The No box under #11 should be checked if no other **eye care** coverage exists. If there is other eye care coverage, the additional information requested is necessary for coordination of benefits.

#21 and **#22** LASIK/PRK

If LASIK or PRK, please make sure your eye care provider marks the Yes box under #21, and includes description of services, procedure code, which eye (left, right or both), and the fee for each eye in the Examination and Treatment Record.

part 2 – eye care provider

To help expedite the claims process, please be sure to include:

#16 National Provider Identifier

There are two types of NPI. Type 1 is for individual providers who operate independently. Type 2 is for health care providers such as group practices or corporations. Type 2 organization providers may want their individual provider employees to have Type 1 NPIs to distinguish them individually.

#20 Statement of actual services, or Pretreatment estimate
Appropriate box should be marked to ensure correct handling.

NOTE: If there are two different providers (one for the exam, another for eyewear), we request that each provider submit a separate claim form.

abbreviations	
VE	vision exam
FR	frame
SV	single vision lenses
BI	bifocal lenses
TR	trifocal lenses
LE	lenticular lenses
PP	progressive lenses
CD	contacts
CN	necessary contacts
CC	cosmetic contacts

pretreatment estimate of benefits

We recommend a pretreatment estimate of benefits when a plan member considers the services to be expensive. A pretreatment estimate lets both the member and eye care provider know in advance how much insurance will pay. If eye care coverage terminates for any reason during treatment, only procedures performed before coverage ended will be eligible for payment.

For full information regarding coverage, plan members may refer to their insurance plan booklet.

website

Visit our website for benefit information, electronic forms, a list of eye care providers if your plan includes a network, and more. Please note, the free software Adobe Reader® (available through the internet) is needed to view and print the electronic forms.