

ROUTINE VISION SERVICE REPORT

**PLEASE FILE WITH YOUR LOCAL BLUE SHIELD PLAN
A SEPARATE CLAIM MUST BE COMPLETED FOR EACH PROVIDER**

PATIENT'S ID NUMBER (INCLUDE PREFIX, MEMBER ID AND SUFFIX)		MEMBER'S GROUP NUMBER(INCLUDE ANY LETTERS)	
PATIENT'S NAME(LAST NAME, FIRST NAME, MIDDLE INITIAL)		PATIENT'S SEX M F	PATIENT'S DATE OF BIRTH
PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE CHILD OTHER			
PATIENT'S STREET ADDRESS			
CITY		STATE	ZIP
TELEPHONE NUMBER (INCLUDE AREA CODE)			
OTHER GROUP INSURANCE OTHER INSURED NAME OTHER INSURED POLICY NUMBER			
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALSO THAT THE ABOVE INFORMATION IS CORRECT		I AUTHORIZE PAYMENT OF BENEFITS TO THE UNDERSIGNED PROVIDER FOR SERVICES DESCRIBED BELOW	
_____ AUTHORIZED PERSON'S SIGNATURE		_____ AUTHORIZED PERSON'S SIGNATURE	
DATE		DATE	

DATE (S) OF SERVICE MM DD YEAR	PLACE OF SERVICE	PROCEDURE CODE	DESCRIPTION OF SERVICES	DIAGNOSIS CODE	CHARGES
	11	V2020	FRAMES		
	11	V2199	SINGLE VISION LENS		
	11	V2299	BIFOCAL LENS		
	11	V2399	TRIFOCAL LENS		
	11	V2781	PROGRESSIVE LENS		
	11	V2599	CONTACT LENS (LIST TYPE)		
	11	S0620	ROUTINE OPHTHALMOLOGICAL EXAMINATION INCLUDING REFRACTION, NEW PATIENT		
	11	S0621	ROUTINE OPHTHALMOLOGICAL EXAMINATION INCLUDING REFRACTION, ESTABLISHED PATIENT		
	11	S0592	COMPREHENSIVE CONTACT LENS EVALUATION		
	11		OTHER SERVICES (EXPLANATION REQUIRED)		

TOTAL CHARGES _____

ONLY ONE PROVIDER'S CHARGES PER CLAIM FORM

TAX ID NUMBER		NPI NUMBER		PATIENT ACCOUNT NO	
PROVIDER'S NAME AND PROFESSIONAL TITLE (LAST NAME, FIRST NAME AND MIDDLE INITIAL)					
PROVIDER'S LOCATION ADDRESS (WHERE SERVICES WERE RENDERED)					
CITY		STATE	ZIP CODE	TELEPHONE NUMBER (INCLUDE AREA CODE)	
I CERTIFY THAT I PERSONALLY RENDERED THE SERVICES DESCRIBED ABOVE TO THIS PATIENT					
_____ PROVIDER'S SIGNATURE					_____ DATE

Vision Claim Filing Checklist

Before filing a vision claim the member should ensure that the following is completed for timely processing:

- ✓ Copy of superbill from a provider's office or sales receipt is attached to claim form
- ✓ Ensure that all documentation is legible and provider's tax identification number is present on a claim
- ✓ Ensure that provider signature is present on claim
- ✓ Ensure that the above documentation is attached to a Routine Vision Service Report