BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

Birmingham Service Center
450 Riverchase Parkway East • Birmingham, AL 35244-2858

VISION/HEARING CLAIM

☐ VISION CLAIM
☐ HEARING CLAIM

TYPE OR PRINT

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. Patient's Name *(First name, middle initial, last name)*

2. Patient's Date of Birth
M M / D D / Y Y Y Y

3. Insured's Name *(First name, middle initial, last name)*

4. Patient's Address *(Street, City, State, Zip Code)*

5. Patient's Sex
☐ MALE ☐ FEMALE

6. Insured's I.D. Number *(Include any letters)*

7. Patient's Relationship To Insured
Self ☐ Spouse ☐ Child ☐ Other ☐

8. Insured's Group Number *(Or Group Name)*

9. Other Health Insurance Coverage
(Name of Policyholder, Plan Name and Address, and Policy or Medical Assistance Number. Attach a copy of your carrier benefit payment notice showing charges submitted and payments made.)

10. Was Condition Related To
A. Patient Employment ☐ YES ☐ NO
B. An Auto Accident ☐ YES ☐ NO
C. An Accident ☐ YES ☐ NO

11. Insured Address *(Street, City, State, Zip Code)*

12. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE	D. TOTAL CHARGES	E. NO. OF SERVICE
M M D D Y Y Y Y	M M D D Y Y Y Y				
	CLAIM TOTAL:				

13. Diagnosis

16. Referring Doctor or Provider

17. Referring Physician UPIN Number

18. Signature of Physician or Supplier

Signed Date

19. Make Payment To:
☐ PROVIDER ☐ PATIENT

20. Physician's or Supplier's Name, Address & Zip Code

Telephone Number
☐☐☐ – ☐☐☐ – ☐☐☐☐

21. Rendering Physician NPI Number

16.		SPHERE	CYLINDER	AXIS	PRISM
DISTANCE	RIGHT				
	LEFT				

The lens prescription must be included for reimbursement of lens purchase.

15. TYPE LENSE
☐ BIFOCAL ☐ TRIFOCAL ☐ PLANO
☐ GLASS LENS ☐ PLASTIC LENS ☐ CONTACT LENS

22. Provider Number	23. Tax ID Number