



**DIRECT DENTAL ADMINISTRATORS, LLC**  
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# VISION CLAIM FORM

**FAILURE TO COMPLETE ALL INFORMATION ON THIS FORM MAY DELAY PROCESSING**

## PART 1 PATIENT INFORMATION (TO BE COMPLETED BY PATIENT)

1. Patient name		2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other		3. Sex <input type="checkbox"/> m <input type="checkbox"/> f		4. Patient birth date MM DD YYYY		5. If full time student School City	
6. Employee name (if different than patient)		7. Employee Social Security No.		8. Employer		9. ID #			
10. Employee mailing address		Street		City		State		Zip code	
11. Are other family members employed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete the following: Name _____ Social Security No. _____ Name and address of employer _____					12. Is patient covered by another medical plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete the following: Vision plan name _____ Carrier _____ Carrier address _____ Policy No. _____				
I have read the following treatment plan. I authorize release of any information relating to this claim. Signed (patient or parent, if minor) _____					I authorize payment directly to the below named provider of the group insurance benefits otherwise payable to me. Signed (employee or authorized person) _____				

## PART 2 TO BE COMPLETED BY DOCTOR      PART 3 TO BE COMPLETED BY DISPENSER

Date of examination		Refraction		Date of order		Date of delivery		Glass Lens	
		No Refraction						Plastic lens	
If you prescribed the glasses check the type (must be completed) <input type="checkbox"/> Single vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Contact				Right lens charge		\$			
Has cataract surgery been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No   Date: _____				Left lens charge		\$			
Can visual acuity be restored to at least 20/70 in the better eye with conventional glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No				Oversize charge, if any		\$			
Is this a prescription change from last year? <input type="checkbox"/> Yes <input type="checkbox"/> No		Best corrected visual acuity Right eye 20/   Left eye 20/		<input type="checkbox"/> Prism charge <input type="checkbox"/> Other		\$			
A.V.S. No.		Examination fee \$		Slab off charge _____		\$			
<b>DOCTOR PRESCRIPTION</b>						Tint charge		\$	
	Sphere	Cylinder	Axis	Prism	Base	Color _____ No. _____		\$	
R.E.	.	.				Frame charge		\$	
L.E.	.	.				Name of frame _____		\$	
						Is frame size over 61 mm?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
						Contact lens charge		\$	
						<input type="checkbox"/> Hard <input type="checkbox"/> Soft			
Reading		R.E.	.	.	L.E.	.	.	TOTAL FOR OPTICAL MATERIALS	
								\$	
Special instructions						Comments			
Signature of doctor						Signature of dispenser			
Please type or print name of doctor						Please type or print name of dispensary			
Tax ID No.						Tax ID No.			
Street Address						Street Address			
City, State, Zip						City, State, Zip			