

**Central IN School Trust
VISION INSURANCE CLAIM FORM**

1. PATIENT'S NAME (Last Name, First Name, Middle Initial)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)									
2.		3. PATIENT'S BIRTHDATE MM DD YY			GENDER M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					7. INSURED'S ADDRESS (No., Street)				
CITY		STATE			8. PATIENT STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student					CITY		STATE		
ZIP		TELEPHONE (Include Area Code) ()								ZIP CODE		TELEPHONE (Include Area Code) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER #053				
9a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO					11a. INSURED'S DATE OF BIRTH MM DD YY				
9b. OTHER INSURED'S DATE OF BIRTH MM DD YY		GENDER M <input type="checkbox"/> F <input type="checkbox"/>			b. AUTO ACCIDENT? PLACE (STATE) <input type="checkbox"/> YES <input type="checkbox"/> NO					11b. EMPLOYER'S NAME OR SCHOOL NAME Central IN School Trust				
9c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11c. INSURANCE PLAN NAME OR PROGRAM NAME Central IN School Trust				
9d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9a-d.				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: _____ DATE: _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: _____				
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$\$\$\$ AMOUNT <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A, B, C, or D TO ITEM 24E BY LINE) A. _____ B. _____ C. _____ D. _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER														
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE of SERVICE	C. TYPE Of SERVICE	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAG CODE	F. \$ CHARGES	G. DAYS Or UNITS	H. EPSDI Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE		
1.														
2.														
3.														
4.														
5.														
6.														
25. FEDERAL TAX I.D. NUMBER		SSN	EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	29. AMOUNT PAID \$		30. BALANCE DUE \$			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS. SIGNED: _____ DATE: _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)			33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE NUMB PIN #: _____ GROUP #: _____						