

CLAIM FOR VISION ASSISTANCE

BELLSOUTH

MAIL TO: SPECTERA

HOW TO FILE YOUR CLAIM

1. YOU COMPLETE PART A
2. HAVE YOUR PHYSICIAN OR OPTOMETRIST COMPLETE PART B
3. HAVE THE SUPPLIER COMPLETE PART C
4. SEND THE COMPLETED FORM TO SPECTERA

BELLSOUTH UNIT
 2811 LORD BALTIMORE DRIVE
 BALTIMORE, MD 21244-2644
 1-800-839-3242

PART A	PATIENT & INSURED INFORMATION	<i>Retirees, Sponsored, and Class II Dependents are not eligible for Vision Care Benefits.</i>
1. PATIENT'S NAME (First, Middle Initial, Last)	2. PATIENT'S BIRTHDAY (MO, DAY, YR) _____	3. EMPLOYEE'S NAME (First, Middle, Last)
	4. IF PATIENT CHILD OVER 19. ARE THEY A FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	OFFICE PHONE # _____
5. EMPLOYEE'S ADDRESS (Street, City/State, Zip)	6. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	7. EMP. SSN: _____
	8. PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	9. EMPLOYEE'S (COMPANY) GROUP NO BST-V-ASO _____
10. OTHER VISION CARE COVERAGE Enter Name of Policy holder, Plan Name, Address, Policy or Medical Assistance number.	11. WAS CONDITION RELATED TO A. AN ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	12. ARE ANY VISION SERVICES PROVIDED BY A HEALTH MAINTENANCE ORGANIZATION? <input type="checkbox"/> YES <input type="checkbox"/> NO LIST SERVICE _____
13. Does your wife/husband work? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what is their Employer's Name?		14. Is Patient Mentally Handicapped? <input type="checkbox"/> YES <input type="checkbox"/> NO
		15. Is Patient Single? <input type="checkbox"/> YES <input type="checkbox"/> NO
16. IS THIS CLAIM RELATED TO VIDEO DISPLAY TERMINAL BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
17. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES. I HEARBY CERTIFY TO THE ABOVE STATEMENTS AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.		
_____ EMPLOYEE'S SIGNATURE		_____ DATE
PART B	EXAMINING PHYSICIAN OR OPTOMETRIST'S INFORMATION	
1. Date of this examination _____ Date of last examination _____ REFERRED BY AN OPTOMETRIST <input type="checkbox"/> YES <input type="checkbox"/> NO	2. Are any of these charges covered by any other insurance, governmental or workers compensation law? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please give the name of other insurance company and name of group _____	
3. Charge for this examination \$ _____	I hereby certify that the above statements accurately describe the services rendered and that I am _____ Licensed to practice by the State of _____ (Signature of Physician)	
Print or type Physician's name	Date	Signature of Physician
(Address)	MUST BE FURNISHED UNDER AUTHORITY OF LAW	
	Individual Practitioner's SSN _____	
	All others - Employer ID NO _____	
PART C	SUPPLIER'S STATEMENT	
The following Lenses and/or Frames were ordered on _____ for the above patient as prescribed on _____ by myself or by Dr. _____		Physician's Tax I.D. No. and SSN (required by Law) for Tax Reporting Purposes.
MATERIALS SUPPLIED	<input type="checkbox"/> Plastic <input type="checkbox"/> Glass	EIN: _____
Type of Lens	No of Lens Charge	SSN: _____
Single Vision _____	\$ _____	
Bifocal _____	\$ _____	
Trifocal _____	\$ _____	
Lenticular _____	\$ _____	
Oversize _____	\$ _____	
Sunglasses _____	\$ _____	
Tint No. _____	\$ _____	
Contact <input type="checkbox"/> Soft <input type="checkbox"/> Hard <input type="checkbox"/> Disposable	\$ _____	
Other (Frames) _____	\$ _____	
Total Charges for Frames/Lenses	\$ _____	
Name of Supplier _____		
Address: _____		
Street	City	State
		Zip Code
Signature _____		Date _____

