

INSURANCE CLAIM FORM FOR VISION CARE

A. CLAIMANT INFORMATION (To be completed by Insured)

Patient Name:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient Address:	Patient Insured Status: <input type="checkbox"/> Self <input type="checkbox"/> Dependant	
Enrollee Name:	Certificate Number:	Dependant Number:
Group Policy Number:	Group Name:	

<p>CLAIMANT'S AUTHORISATION</p> <p>I authorise Cayman First to obtain medical records from any medical service provider, insurer, employer or other source deemed necessary to settle this claim.</p> <p>Signature _____ Date _____</p>	<p>PAYMENT ASSIGNMENT</p> <p>I authorise Cayman First to pay the proceeds of this claim to the undersigned Vision Care Provider(s).</p> <p>Signature _____ Date _____</p>
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B. VISION CARE SERVICES PROVIDED (To be completed by Ophthalmologist or Optometrist)

Vision Care Provider Name:	Telephone No.:
Vision Care Provider Address:	
Has cataract surgery been performed? <input type="checkbox"/> No <input type="checkbox"/> Yes	Does patient require a prescription change at this time? <input type="checkbox"/> No <input type="checkbox"/> Yes

Diagnosis: _____

Date of Service: _____

Visual acuity	PRESCRIPTION					FEE: \$
	Sphere	Cylinder	Axis	Prism	Base	
R.E.	-	-				PAID BY PATIENT: \$
L.E.	-	-				
READING ADD		R.E.	+ '	L.E.	+ '	BALANCE DUE: \$

I hereby certify that this is a true statement of treatment and services rendered.

Signature of Ophthalmologist/ Optometrist _____ Date _____

C. VISION CARE PRESCRIPTION FILLED (To be completed by Optician or Vision Care Laboratory)

Optician Name:	Telephone No.:
Optician Address:	

PROFESSIONAL SERVICES

SERVICES RENDERED/ ITEMS SUPPLIED	FEES \$	INS. CO. ONLY
Frame Manufacturer Name: _____ Model or Cat. No. and Size: _____		
Lenses: <input type="checkbox"/> None <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular <input type="checkbox"/> Other _____		
Contact Lenses: <input type="checkbox"/> None <input type="checkbox"/> Therapeutic <input type="checkbox"/> Non-Therapeutic <input type="checkbox"/> Hard Lenses <input type="checkbox"/> Soft Lenses		

I hereby certify that this is a true statement of treatment and services rendered.

TOTAL FEES: _____

PAID BY PATIENT: _____

BALANCE DUE: _____

Signature of Optician/ Vision Care Lab Manager _____ Date _____