



**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<br><input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other |  | 3. Sex<br><input type="checkbox"/> m <input type="checkbox"/> f |                                                                                                                                                                                                                                     | 4. Patient birth date<br>MM DD YYYY |  | 5. If full time student<br>School<br>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"/><br>If yes, complete the following:<br>Name _____<br>Social Security No. _____<br>Name and address of employer _____ |  |                                                                                                                                                            |  |                                                                 | 12. Is patient covered by another medical plan? Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, complete the following:<br>Vision plan name _____<br>Carrier _____<br>Carrier address _____<br>Policy No. _____ |                                     |  |                                           |  |
| I have read the following treatment plan. I authorize release of any information relating to this claim.<br>Signed (patient or parent, if minor) _____                                                              |  |                                                                                                                                                            |  |                                                                 | I authorize payment directly to the below named provider of the group insurance benefits otherwise payable to me.<br>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)<br><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?<br><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?<br><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<br>Right eye 20/   Left eye 20/ |      | <input type="checkbox"/> Prism charge <input type="checkbox"/> Other |      | Slab off charge _____                                                              |  | \$                                                       |  |
| A.V.S. No.                                                                                                                                                                                                     |        | Examination fee<br>\$                                        |      | Tint charge                                                          |      | Color _____ No. _____                                                              |  | \$                                                       |  |
| <b>DOCTOR PRESCRIPTION</b>                                                                                                                                                                                     |        |                                                              |      | Frame charge                                                         |      |                                                                                    |  | \$                                                       |  |
|                                                                                                                                                                                                                | Sphere | Cylinder                                                     | Axis | Prism                                                                | Base | Name of frame _____                                                                |  | \$                                                       |  |
| R.E.                                                                                                                                                                                                           | •      | •                                                            |      |                                                                      |      | Is frame size over 61 mm?                                                          |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| L.E.                                                                                                                                                                                                           | •      | •                                                            |      |                                                                      |      | Contact lens charge<br><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                                                                   |  |                                                          |  |