VISION AND HEARING CLAIM FORM

Submit claim form along with itemized bill and receipts for services to:
Fax: (833) 517-1852

Mail: Careington Benefit Solutions, P.O. Box 21681, Eagan MN 55121
Attention: Claims

PLEASE READ BEFORE COMPLETING THIS FORM

The furnishing of this form is for the convenience of the policyholder and is not an acknowledgment of liability or waiver of any right.

INSTRUCTIONS:

1. Complete Policyholder and Patient Information on this page.
2. Be sure to sign your claim form at the bottom of this page.
3. Failure to complete this form in its entirety may result in a delay in processing this claim.

SUPPORTING DOCUMENTATION:

1. Submit all itemized statements related to this claim. They should be itemized and should include the diagnosis, services rendered, date of service and charges for the service.
2. Be sure to include your policy number on all documents.

PATIENT'S INFORMATION

Patient's Name (Last, First, Middle Initial)	Policy Number	Date of Birth

Address (City, State, Zip Code)

Telephone Number	Relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Check if dependent is a full-time student

Services Rendered: ☐ Vision ☐ Hearing	Date of Service:

Procedure Code	Modifier (if any)	Code Description	Amount Charged
		Total Charged	

Physician Name and Address	NPI	Tax ID

I authorize any hospital, physician or other person who has attended me or examined me to disclose to my insurer or their duly authorized representative any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment relative to my person, and to furnish copies of all hospital or medical records. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original. I understand and agree that if payment of benefits to me results in an overpayment, the Company may deduct the amount of the overpayment from future benefit payments.

Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of insurance fraud, which is a felony.

Signature (if claim is for a minor, parent or legal guardian must sign) ____________________ Date ____________