

VISION CARE OUT OF NETWORK CLAIM FORM

PROVIDER NO: _____

 PLAN NAME: **ABX AIR, INC.**

 PLAN NO: **40840**


TO CHECK THE MEMBER'S BENEFITS CALL 1-800-359-8989

P A T I E N T I N F O	INSURED NAME (Last Name, First Name)		PATIENT NAME (Last Name, First Name)		INSURED SOCIAL SECURITY NUMBER	
	ADDRESS	CITY	STATE	ZIP	PATIENT DATE OF BIRTH	RELATIONSHIP TO MEMBER: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
I acknowledge receiving the services specified below. I authorize release of any information related to this claim to the Plan and/or Claims Administrator of this Vision Care Plan. Any allowable or covered benefits will be reimbursed to the insured or to the party who accepts assignment below.						
PATIENT'S SIGNATURE: _____				DATE: _____		

(Doctor: If this is your first time filing a claim through Cole Managed Vision, you must submit a W-9 form, as completed with IRS, with this claim in order to receive payment. You can download a copy off of the web at <http://ftp.fedworld.gov/pub/irs-pdf/fw9.pdf>.

E X A M I N E R	DATE OF SERVICE: <small>(Month / Day / Year)</small>	SERVICE RENDERED: <input type="checkbox"/> Spectacle Exam <input type="checkbox"/> DW Contact Lens Exam <input type="checkbox"/> EW Contact Lens Exam	NORMAL EXAM FEE \$	DILATION FEE (if administered) \$		
	DIAGNOSIS:	ICD.9 CODE:	CPT CODE:			
PROVIDER'S NAME		ADDRESS	CITY	STATE	ZIP	TELEPHONE NO. <small>Area Code ()</small>
FEDERAL TAX I.D. NUMBER		ACCEPT ASSIGNMENT? (Exam Portion)				
		<input type="checkbox"/> SSN <input type="checkbox"/> EIN		<input type="checkbox"/> YES _____		<input type="checkbox"/> NO
Doctor's Signature (Please attach W-9)						

M A T E R I A L S	DATE ORDERED:	DATE DISPENSED:	Sphere	Cylinder	Axis	Prism	Add
			R				
			L				
FRAME NAME:		Retail \$				ACCEPT ASSIGNMENT? (Materials Portion)	
LENS TYPE		OPTIONS		CONTACTS			
<input type="checkbox"/> Single Vision \$		<input type="checkbox"/> Polycarbonate \$		<input type="checkbox"/> Hard \$		<input type="checkbox"/> YES (Please attach W-9)	
<input type="checkbox"/> Bifocal \$		<input type="checkbox"/> Progressive \$		<input type="checkbox"/> Soft \$		Optometrist's Signature	
<input type="checkbox"/> Trifocal \$		<input type="checkbox"/> Scratch Coating \$		<input type="checkbox"/> Daily Wear \$		<input type="checkbox"/> NO	
<input type="checkbox"/> Other \$		<input type="checkbox"/> Ultra-Violet Coating \$		<input type="checkbox"/> Extended Wear \$		FEDERAL TAX I.D. NUMBER	
		<input type="checkbox"/> Warranty \$		<input type="checkbox"/> Other \$		<input type="checkbox"/> SSN <input type="checkbox"/> EIN	

<p style="text-align: center;">LOCATION WHERE SERVICE PROVIDED:</p> Store Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone Number: (____) _____ - _____ Optician Signature: _____	<p>MAIL CLAIM TO:</p> <p>Claims must be submitted within 12 months from date of service.</p>  <p>Billing Department 1925 Enterprise Parkway PO Box 8056 Twinsburg, Ohio 44087</p>
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Cole Vision Services Federal I.D. # 34-1733137

CLAIM SUBMISSION OR CALLING FOR BENEFITS ARE NOT A GUARANTEE OF PAYMENT. PATIENT MUST BE ELIGIBLE FOR SERVICE RENDERED.

A/P USE ONLY

INSTRUCTIONS FOR COMPLETING THE OUT OF NETWORK CLAIM FORM

1. Sign the claim form in the “Patient’s Information” section.
2. Attach an itemized copy of your bill that gives a breakdown of the cost and type of:
 - Frame
 - Lens
 - Lens Option
 - Contact Lenses
 - Exam
3. **PROVIDERS ONLY**: If you choose to accept assignment :
 - If this is your first claims submission to Cole Managed Vision (CMV), attach a completed W-9 as filed with the IRS. If you have previously submitted a claim to CMV, complete the field marked “Federal Tax I.D. Number”.
 - Have the patient sign the form.
4. Return the completed form and itemized bill to:

Cole Managed Vision
Attn: Claims Department
1925 Enterprise Parkway
P. O. Box 8056
Twinsburg OH 44087

Claims properly filled out will be processed within 1-2 weeks of receipt.
Payment may be delayed on any claim missing information.

Please call 1-800-359-8989 have any questions.