COLE MANAGED VISION

VISION CARE OUT OF NETWORK CLAIM FORM

PROVIDER NO: _____

PLAN NAME: _____ PLAN NO: _____

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

PATIENT INFO

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:
		☐ Self ☐ Spouse ☐ 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:** _____

EXAM

(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.

DATE OF SERVICE: (Month / Day / Year)	SERVICE RENDERED:	NORMAL EXAM FEE	DILATION FEE (If administered)
	☐ Spectacle Exam ☐ DW Contact Lens Exam ☐ EW Contact Lens Exam	$	$

DIAGNOSIS:	ICD.9 CODE:	CPT CODE:

PROVIDER'S NAME ADDRESS CITY STATE ZIP	TELEPHONE NO.
	Area Code ( )

FEDERAL TAX I.D. NUMBER	ACCEPT ASSIGNMENT? (Exam Portion)
☐ SSN ☐ EIN	☐ YES _____ ☐ NO
	Doctor's Signature (Please attach W-9)

MATERIALS

DATE ORDERED:	DATE DISPENSED:		Sphere	Cylinder	Axis	Prism	Add
		R					
		L					

FRAME NAME: _____ Retail $ _____

ACCEPT ASSIGNMENT? (Materials Portion)

☐ YES (Please attach W-9)

Optometrist's Signature

☐ NO

FEDERAL TAX I.D. NUMBER

☐ SSN ☐ EIN

LENS TYPE	Retail	OPTIONS	Retail		Retail	CONTACTS	Retail
☐ Single Vision	$	☐ Polycarbonate	$	☐ Solid Tint	$	☐ Hard	$
☐ Bifocal	$	☐ Progressive	$	☐ Gradient Tint	$	☐ Soft	$
☐ Trifocal	$	☐ Scratch Coating	$	☐ Photochromic	$	☐ Daily Wear	$
☐ Other	$	☐ Ultra-Violet Coating	$	☐ A/R Coating	$	☐ Extended Wear	$
		☐ Warranty	$	☐ Other	$	☐ Other	$

LOCATION WHERE SERVICE PROVIDED:

Store Name: _____

Address: _____

_____

City _____

State _____ Zip Code _____

Phone Number: ( ) _____ -

Optician Signature: _____

MAIL CLAIM TO:

Claims must be submitted within 30 days from date of service.

COLE MANAGED VISION

Billing Department

1925 Enterprise Parkway

PO Box 8056

Twinsburg, Ohio 44087

Cole Vision Services Federal I.D. # 34-1733137

Rev. 2/01

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
   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.