NORTHWEST BENEFIT NETWORK – VISION PLAN

ELIGIBILITY AUTHORIZATION # _____

NAME OF GROUP _____ **PLAN #** _____

EMPLOYEE INFORMATION

FIRST NAME	LAST NAME	DATE OF BIRTH	SPOUSE'S DATE OF BIRTH
STREET ADDRESS	CITY	ST / ZIP	HOME PHONE
SOCIAL SECURITY NO.	NAME OF EMPLOYER		LOCAL UNION

PATIENT INFORMATION

THIS CLAIM IS FOR

- ☐ SELF
- ☐ SPOUSE
- ☐ DOMESTIC PARTNER
- ☐ CHILD
- ☐ STEP-CHILD
- ☐ OTHER _____

FIRST NAME _____ LAST NAME _____ DATE OF BIRTH _____ ☐ MALE ☐ FEMALE

IS THE PATIENT A FULL TIME STUDENT? YES ☐ NO ☐ If Yes, all information in the shaded box is **REQUIRED**

NAME OF SCHOOL CURRENTLY ATTENDING _____

LAST 4 QUARTERS ATTENDED FALL YR _____ WINTER YR _____ SPRING YR _____ SUMMER YR _____

IF NOT ATTENDING SUMMER QUARTER, IS PATIENT ENROLLED FOR COMING FALL QUARTER? ☐ YES ☐ NO

IF NO, WHEN WAS LAST DAY ATTENDED? MONTH _____ YEAR _____

OTHER COVERAGE INFORMATION (COMPLETION OF THIS SECTION IS REQUIRED)

DOES THE PATIENT HAVE OTHER VISION COVERAGE ☐ YES ☐ NO

IF YES, NAME OF PERSON WITH OTHER VISION COVERAGE _____ THEIR RELATIONSHIP TO THE PATIENT _____ DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

IF YES, NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THESE SERVICES _____ POLICY NUMBER _____

WAS VISION CARE REQUIRED BECAUSE OF AN INJURY? ☐ YES ☐ NO IF YES, ANSWER QUESTIONS BELOW

WAS INJURY CAUSED BY YOUR WORKS?	HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKERS COMPENSATION CARRIER?	IS VISION RQUIRED AS A CONDITION OF YOUR EMPLOYMENT?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF . I HEREBY AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE TO FURNISH AND DISCLOSE ALL FACTS CONCERNING THIS CLAIM. I AGREE THAT, IF MY PLAN DOES NOT PROVIDE COVERAGE FOR THE EXPENSES INCURRED OR I AM NOT ELIGIBLE FOR BENEFITS, I WILL BE RESPONSIBLE FOR PAYMENT OF ALL CHARGES.

DATE _____ **EMPLOYEE'S SIGNATURE** _____

* NOTE TO PROVIDERS *

THE LOWER PORTION OF THIS CLAIM MUST BE COMPLETED BY THE ATTENDING PANEL PROVIDER

IF YOU ARE NOT AN NBN PANEL PROVIDER, PLEASE PROVIDE THE PATIENT WITH AN ITEMIZED BILL. YOU DO NOT NEED TO COMPLETE THIS CLAIM FORM.

NAME OF PROVIDER TO BE PAID		DEGREE(S)
MAILING ADDRESS	TAX ID NUMBER	PROVIDER'S NBN NUMBER
CITY / ST / ZIP	DATE SERVICES BEGAN	DATE SERVICES COMPLETED

I hereby certify that I personally performed the professional services and have billed NBN no more than my usual and customary fee

Signature of Attending Provider _____ Date _____

EXAMINATION	EXAM FEE	LENS	LENS COST
☐ COMPREHENSIVE		☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ PROGRESSIVE ☐ OTHER _____ ☐ GLASS ☐ PLASTIC	
☐ INTERMEDIATE			
☐ LIMITED			
CONTACT LENS	**CONTACT EXAM FEE**	**CONTACT LENS**	**CONTACTS COST**
☐ EVALUATION/FITTING		☐ DISPOSABLE ☐ STANDARD ☐ GAS PERMEABLE / HARD	
SUBNORMAL VISION AID		**FRAMES**	**FRAMES COST**
		☐ PATIENT'S FRAME ☐ NEW FRAME IF NEW FRAME, BELOW IS **REQUIRED**	
		NAME	
		STYLE	
		MANUFACTURER	
		TAX RATE	TOTAL

PLEASE SEND A COMPLETED AND SIGNED COPY TO:

NORTHWEST BENEFIT NETWORK

2323 EASTLAKE AVENUE EAST, SEATTLE, WA 98102

(206) 726-3278 (800) 732-1123 WWW.NWADMIN.COM

PROVIDER, PLEASE SEND ONE COPY TO AN NBN APPROVED LAB AND KEEP ONE COPY FOR YOUR RECORDS.

NBN COPY ☐ **LAB COPY** ☐ **PROVIDER COPY** ☐