45 Nob Hill Road, P.O. Box 7338 | Madison, Wisconsin 53707-7338
800.279.4000   WEAtrust.com

Routine Vision Claim Form

National Vision Administrators processes claims for routine vision coverage provided under the WEA Trust Essential Vision Plan and the WEA Trust WEA-MedPlus Plan. If you have more than one vision plan, you or your vision provider must submit to our Administrator a completed claim form labeled "COB" and an explanation of benefits from the primary plan.

CLAIM INSTRUCTIONS

- Use this form to obtain reimbursement for services
- Part A to be completed by Employee
- Part B to be completed by your Eye Care Professional (Optional)
- Submit the form to: National Vision Administrators, L.L.C.
  P.O. Box 2187
  Clifton, New Jersey 07015

If you have questions, please contact NVA at (877) 262-7915.

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Routine Vision Claim Form

PRINT ALL INFORMATION

PART A – TO BE COMPLETED BY EMPLOYEE

1. EMPLOYEE'S NAME (Last, First, Middle)	2. EMPLOYEE'S ADDRESS (No., Street, State, and Zip Code)
3. EMPLOYEE'S SOCIAL SECURITY NUMBER	4. TELEPHONE NUMBER
5. EMPLOYER NAME	6. EMPLOYER ADDRESS (No., Street, State, and Zip Code)

7. PATIENT'S NAME (Last, First, Middle)	8. PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ Self ☐ Spouse ☐ Child ☐ Handicapped ☐ Student ☐ Other ______	9. PATIENT'S SEX ☐ Male ☐ Female	10. PATIENT'S DATE OF BIRTH
11. IS PATIENT COVERED FOR VISION CARE BY ANOTHER PLAN? ☐ NO ☐ YES	VISION PLAN NAME	GROUP NO.	NAME AND ADDRESS OF CARRIER

12.
Any person who knowingly and with intent to defraud any insurance company or other person; files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PART B – TO BE COMPLETED BY EYE CARE PROFESSIONAL (OPTIONAL)

1. DOCTOR'S NAME (Last, First, Middle)	2. TAXPAYER IDENTIFICATION NO.	PROFESSIONAL SERVICES	AMOUNT
3. DOCTOR'S ADDRESS (No., Street, City, State, and Zip Code)		EYE EXAMINATION	
4. PHONE NO. (and Area Code) / 5. TITLE ☐ M.D. ☐ D.O. ☐ O.D. / 6. EXAMINATION DATE(S)	7. WAS CATARACT SURGERY PERFORMED? ☐ NO ☐ YES	CONTACT LENS EXAM (if any)	
8. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTIONAL EYEGLASSES? ☐ NO ☐ YES	9. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? ☐ NO ☐ YES		
10. DIAGNOSTIC CODE(S)		AMOUNT PAID BY PATIENT	

11. INDICATE DIAGNOSIS OR NATURE OF DISEASE, INJURY, OR VISION DISORDER. CODE #'S INDICATE PROCEDURE	12. VISUAL ACUITY CORRECTED TO:

13.

DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
R.E.		•			
L.E.		•			
READING ADD		R.E.	+ •	L.E.	+ •

14. I hereby certify that I have performed the services as indicated heron.

DOCTOR'S SIGNATURE ______ DATE ______

PART C – TO BE COMPLETED BY DISPENSER

1. DISPENSER'S NAME (Last, First, Middle)	2. TAXPAYER IDENTIFICATION NO.
3. DISPENSER'S ADDRESS (No., Street, City, State, and Zip Code)	4. PHONE NO. (and Area Code)

5. PROFESSIONAL SERVICES:

	DATES(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS
1													
2													
3													
4													
5													
6													

6. PATIENT'S ACCOUNT NO.	7. TOTAL CHARGE $	8. AMOUNT PAID $	9. BALANCE DUE $

10. I hereby certify that I have performed the services as indicated hereon.

DISPENSER'S SIGNATURE ______ DATE ______