Sagicor

# VISION CARE CLAIM FORM

**NOTE: CLAIMS MUST BE SUBMITTED WITHIN 3 MONTHS OF BEING INCURRED TO BE ELIGIBLE FOR REIMBURSEMENT**

| TO BE COMPLETED BY THE EMPLOYEE | TO BE COMPLETED BY THE EMPLOYER (complete for every claim) |
|---|---|
| 1. Insured's Name | Company or Group Name |
| 2. Home Address | Policy Number |
| 3. Claim incurred by? (Patient) | Certificate Number |
| 4. Patient's Address | Class or Coverage Code |
| 5. Relationship of Patient to Insured | Insured's Effective Date (d/m/y) |
| 6. Date of Birth of Patient (d/m/y) | Dependent's Effective Date (d/m/y) |
| 7. Is spouse employed? ☐ Yes ☐ No (if "Yes", give name of employer) | Date (d/m/y) |
| 8. Are you or any of your dependents covered by any other HEALTH insurance benefits for these expenses? ☐ Yes ☐ No | Employer's Signature |
| 9. If "Yes", Name of Group or Company insured under. | |

10. Check if statements/bills for ALL expenses are attached in support of your claim ☐ Yes ☐ No

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors or other persons who treated me and all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to SAGICOR LIFE INC.

**Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or with intent to mislead, conceals information concerning any fact material thereto, commits a fraudulent act and is liable to prosecution**.

Date: _____ _____ _____

Signature of Insured Signature of Spouse (If Patient)

**ASSIGNMENT OF INSURANCE BENEFITS (complete only if payment is to be made to other than the insured)**

(a) OPTOMETRIST/OPHTHALMOLOGIST/OPTICIAN BENEFITS

I hereby authorize the Insurance Company to pay to _____ whatever eye examination benefits I may be entitled to under Group Policy No._____ with respect to the expenses incurred on behalf of the named patient on _____

(b) PROVIDER OF SUPPLIES

I hereby authorize the Insurance Company to pay to _____ whatever benefits I may be entitled to under Group Policy No._____ with respect to the frames, lenses, contact lenses purchased on_____

"I hereby certify that the above services as indicated by date have been completed."

Date: _____ Signature of Insured _____

**PHYSICIAN AND SUPPLIER INFORMATION**

(a) Diagnosis or Description of Condition _____ (b) Did prescription change for ☐ Right eye ☐ Left eye

(c) Date Dispensed_____ (d) Cost of Examination_____

Were contact lenses prescribed for severe corneal astigmatism, corneal scarring, keratoconus or aphakia? ☐ Yes ☐ No

Can visual acuity be improved by up to at least the 20/70 level by spectacle lenses? ☐ Yes ☐ No

Can visual acuity be improved by up to at least the 20/70 level by contact lenses? ☐ Yes ☐ No

"I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED."

Date: _____ Signature of Optometrist/Ophthalmologist/Optician _____

Optical supplies furnished by _____ Address _____

(a) Laboratory cost of Lenses $_____

(b) Please specify type of Lenses

☐ Single ☐ Bifocal
☐ Multifocal ☐ Lenticular
☐ Contacts

(c) Tinting $_____

Specify Tone Light ☐ 1 ☐ 2 ☐ 3

(d) Are these prescription sun glasses? ☐ Yes ☐ No
Replacement of lost of damaged glasses? ☐ Yes ☐ No
Photogrey/Photosun:_____

(e) Cost of Frames $_____

(f) Hardex/safety material_____

(g) Other, please specify _____

"I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED."

Date: _____ Signature of Optometrist/Ophthalmologist/Optician _____

# GUIDELINES

Our goal is to process your claim within the **10 day turnaround** time we have indicated to you. In order for us to fulfil this goal, you can help us by ensuring that the following guidelines are followed:

## THE CLAIM FORM

- Prepare **a separate claim form** for each family member.
- Complete **ALL** of the information requested with **EACH** claim submission.
- If you prefer that **benefits be paid to the provider of services, be sure to complete the authorization for assignment of benefits** section of the claim form.

## THE PROVIDER BILLING OR RECEIPT

Each bill receipt should carry:

- The name, address, person or organization providing the service.
- The name of the patient receiving the service.
- The date of each service **(a range of services cannot be accepted)**.
- The charge for each individual service.
- A description of each service.

On each bill, please delete any charges that were included on a previous claim. Personal itemizations, cash register receipts, credit card receipts and cancelled cheques are not acceptable. **PLEASE NOTE THAT ORIGINAL RECEIPTS CANNOT BE RETURNED UNLESS ACCOMPANIED BY CLEAR COPIES.**

**Accidental Injury** - Statements must contain details as to when, where and the manner in which the injury occurred as well as the name and address of the party at fault where applicable.

**Prescription only drugs** - Bills/receipts must include the prescription number, the name of the drug and
the name of the physician prescribing the medication. **(Please note that the cost of each drug must be indicated and receipts must carry the name/stamp of the pharmacy )**

**Private Duty Nursing** - Bills/receipts must include the shift worked, the charge per hour, the number of hours worked, the nurse's professional status, the family relationship to the patient if any. A statement from the attending physician explaining the necessity of this service and the authorization of the service should accompany the claim.

**Prosthetic appliances and the rental or purchase of durable equipment** - A statement from the attending physician should accompany the claim. The statement should explain the medical necessity of the equipment and the physician's authorization for it.

**For patients covered by another insurance carrier** - If the patient is claiming benefits for any charges that are eligible for benefits under any other health insurance policy, the explanation of benefits worksheet furnished by the other company pertaining to these expenses must be included with the itemized bills. A CLEAR copy of the other carrier's explanation of benefits worksheet is acceptable in place of the original document.

Have you?

- ☒ Fully completed and signed the claim form.
- ☒ Attached all relating itemized bills/receipts.
- ☒ Kept copies of documentation for your records.
- ☒ Had your Plan administrator complete the employer's section.

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