

Vision Treatment Benefit Claim Sheet

Patient Information			
Patient Name:	Date of Birth:	Policy Number:	Member ID:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address:		Phone Number:	Email:
<input type="text"/>		<input type="text"/>	<input type="text"/>
Claim Details			
Date of Service:		Provider Name:	
<input type="text"/>		<input type="text"/>	
Type of Service (Exam, Frames, Lenses, etc.):	Total Cost:	Amount Requested:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Authorization			
Signature:		Date:	
<input type="text"/>		<input type="text"/>	