VISION CLAIM FORM

PROVIDER SUPPORT:
1.954.331.6530, OPTION 4

Forward Form and Bills to:
JIPA Network/Claims
PO Box 2788
Kennesaw, GA 30156-9114 USA
fax: 1.770.810.3789
email: claims@jipanetwork.com

(Please Print)

Group/Plan Name or Number:	Insured's ID Number:

PART 1 MUST BE COMPLETED BY INSURED

Insured's Last Name: First: Middle:	Patient's Birth Date: mm/dd/yyyy	Patient's ID Number:
Patient's Last Name: First: Middle:	Patient's Gender: ❑ M ❑ F	Patient's Relationship to Insured:
Street Address:	Home Phone #: ( ) EMail Address:	Cell Phone #: ( )
City/Town:	Parish/State:	ZIP/Postal Code:

ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits. I hereby certify the information provided is true and correct to the best of my knowledge.

X _____ _____
Patient's Signature *Date*

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S):
I hereby authorize payment of benefits directly to Providers submitting claims on my behalf. This payment shall not exceed my indebtedness to the Providers and I have agreed to pay, in a current manner, any charges determined to be not covered by the plan benefits.

X _____ _____
Patient's Signature *Date*

PART 2 TO BE COMPLETED BY PROVIDER OF SERVICE

Doctor's Name, Title, Address:	Examination Date(s):	Indicate diagnosis or nature of disease or injury or vision disorder:
	Does Patient require a prescription change at this time? ❑ Yes ❑ No	Diagnosis Codes:
Phone: ( ) _____ Company TIN: _____	Visual acuity corrected to:	Reading Add: R.E. L.E.

	Sphere	Cylinder	Axis	Prism	Base
R.E.					
L.E.					

Professional Services Exam Code(s): _____ CPT or Procedure Code
Refraction Included: ❑ Yes ❑ No _____ CPT or Procedure Code
Other: _____

Professional Charges: _____ Currency: _____
Refraction Charges (if any): _____ _____
Amount Paid by Patient: _____ _____
Balance Due: _____ _____

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged the patient and intend to accept for those procedures.

_____ _____
Doctor's Signature Date

NOTE: IN LIEU OF DISPENSER COMPLETING THIS SECTION A LABORATORY BILL CAN BE ATTACHED.

Dispenser's Name, Title, Address & Phone Number:	❑ Order Date: _____ ❑ Deliver Date: _____	Material Supplied: ❑Glass ❑Plastic ❑Oversized ❑Tint # _____ ❑Pair ❑1/2 Pair ❑Other _____
Phone: ( ) _____ Company TIN: _____	Lenses for: ❑ One Eye ❑ Both Eyes	Frames: ❑ Existing ❑ New

Type of lenses dispensed: (CPT or Procedure Code)
- ❑ None
- ❑ Single _____
- ❑ Bifocal _____
- ❑ Trifocal _____
- ❑ Lenticular _____
- ❑ Contacts _____
- ❑ Sunglasses _____
- ❑ Other _____

Contact Lenses: (CPT or Procedure Code)
- ❑ Therapeutic _____
- ❑ Non-Therapeutic _____
- ❑ Hard Lenses _____
- ❑ Soft Lenses _____
- ❑ Gas Permeable _____

Frames:
- ❑ Frames _____

Professional Services: Currency Type:

Lens Charge:	_____	_____
Frame Charge:	_____	_____
Optional Lens Charge:	_____	_____
Optional Frame Charge:	_____	_____
Dispensing Lens Charge:	_____	_____
Dispensing Frame Charge:	_____	_____
Sales Tax (if any):	_____	_____
Total Due:	_____	_____
Amount Paid by Patient:	_____	_____
Balance Due:	_____	_____

I hereby certify that I have performed the services as indicated hereon and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.

_____ _____
Dispenser's Signature Date