ALL INFORMATION
RECORDED ON THIS FORM
IS CONFIDENTIAL

claimsecure

GENERIC VISION CARE CLAIM FORM

CLAIMSECURE INC.
43 ELM STREET, SUITE 200,
SUDBURY, ONTARIO P3C 1S4
1-888-513-4464

IDENTIFICATION OF THE INSURED

Last Name	First Name
Address	Apt.
City	Province
Telephone	Postal Code
Date of Birth (YYYY/MM/DD)	Employee Cert./SIN/ID No.
Policy/Group/Plan No.	Account No./Division/Section
Insurance Company	Employer Name

IDENTIFICATION OF THE PATIENT

Last Name	First Name
If Patient address is different – please complete:	
Patient Identification Number	Date of Birth (YYYY/MM/DD)

Relationship with the insured ❑ PLAN MEMBER ❑ DEPENDENT ❑ SPOUSE ❑ SPECIAL DEPENDENT ❑ STUDENT

NAME OF EDUCATIONAL INSTITUTION IF APPLICABLE:

IDENTIFICATION OF THE PROVIDER

Name	
Address	
City	Province
Telephone	Postal Code
Permit No./License No.	Insurance Carrier Provider No.

SPOUSE/ALTERNATE COVERAGE – COORDINATION OF BENEFITS

WCB/WSIB? ❑ Yes ❑ No

Do you have other Vision Care coverage? ❑ Yes ❑ No

If yes, please complete the following:

Name of Insurer/Plan _____ Name of Insured _____

Effective Date of Coverage (YYYY/MM/DD) _____

Policy/Group/Plan No. _____ Coverage ❑ Family ❑ Single

Alternate coverage/Employee Cert./SIN/ID No. _____

Spouse or Alternate Date of Birth (YYYY/MM/DD) _____

If this is your first claim, or if information has changed, please specify:

Either a copy of the payment or denial letter from the primary carrier must be attached.

DETAILS OF THE PRESCRIPTION

		Sphere	Cylinder	Axis	Prism	Add
New Rx	Right					
	Left					
Old Rx	Right					
	Left					

Plastic ❑ Type of right lens _____

Hardened ❑ chem Type of left lens _____

❑ Heat Tint _____

Oversize: _____ mm

❑ initial prescription ❑ prescription sunglasses ❑ Rx duplicate

❑ new prescription ❑ contact lenses ❑ replacement (loss or breakage)

❑ safety glasses ❑ lenses only

❑ post cataract

❑ other: (indicate any medical conditions or disease) _____

If claim is for contact lenses:

Can visual acuity be restored to ❑ 20/70? ❑ 20/40?

Are the contact lenses medically necessary due to keratocunus, irregular astigmatism, aphakias, or irregular corneal curvature? ❑ Yes ❑ No

Can visual acuity be improved by at least two lines on the Snelian chart over the best possible vision with glasses? ❑ Yes ❑ No

CLAIM DETAILS

Please attach copies of the original Paid in Full receipt if claim payable to Insurer

DISPENSING DATE YYYY/MM/DD	SERVICE CODE	SERVICE DESCRIPTION (When required, specify dispensing fees separately.)	Quantity	Dispensing Fee	Price
				Total $	
				Patient Paid $	

ASSIGNMENT DETAILS:

I hereby assign my benefits payable from this claim and authorize payment directly to the above Service Provider

Insured's signature _____

CONTRACT HOLDER/ADMINISTRATOR DETAILS:

Dates (YYYY/MM/DD)

Eligible _____

Dependent Eligible _____

Terminated _____

Is treatment the result of an occupational illness or injury, or otherwise related to employment? ❑ Yes ❑ No

Contract Holder and Location: _____

Signature of Authorized Official: _____ **Date:** _____

Administrator Signature: _____ (YYYY/MM/DD)

PICK UP DATE (YYYY/MM/DD) _____

Balance to be paid to provider $

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member.

I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan.

A copy of this authorization shall be as valid as the original.

Insured's signature: _____ ***Date:*** _____

Provider's signature: _____ ***Date:*** _____