EYE EXAMINATION AND OPTICAL SERVICE EXPENSE STATEMENT

Completed Form and Bills to be Returned to:

Planned Administrators, Incorporated
P.O. Box 6839
Columbia, SC 29260
Telephone Number: 1 800 768-4375
Fax Number: 803-870-8012

FOR OFFICE USE ONLY

CLAIM NO.

BCS GROUP NUMBER	PATIENT'S NAME (PLEASE PRINT) LAST	FIRST	MI	SEX	AGE	PATIENT'S BIRTH DATE
B2808033						

SOCIAL SECURITY NO. OF INSURED	ACTIVE ☐	RETIRED ☐	NAME OF INSURED	RELATIONSHIP OF PATIENT TO INSURED

INSURED'S ADDRESS: NUMBER | STREET | CITY | STATE | ZIP CODE

NAME OF COMPANY WHERE INSURED IS EMPLOYED

NAME OF PROVIDER OF SERVICE

ADDRESS (NO. AND STREET)

CITY | STATE | ZIP CODE

IS PATIENT COVERED BY ANOTHER INSURANCE PLAN?
NO ☐ YES ☐

IF YES, PLEASE COMPLETE:
CARRIER
ADDRESS
CITY & STATE
POLICY/GROUP NO.
NAME OF INSURED

FOR DEPENDENT CHILDREN AGE 19 OR OLDER, IS PATIENT A FULL-TIME STUDENT?
NO ☐ YES ☐

LICENSE NO.

I.R.S. IDENTIFICATION (SOCIAL SEC. OR EMPLOYER NO.)

DATE OF PATIENT'S FIRST VISIT

TREATMENT RESULT OF:
ACCIDENT? ☐ NO ☐ YES
OCCUPATION? ☐ NO ☐ YES

ARE ANY OF THE SERVICES FOR SURGICAL TREATMENT OF THE EYES?
☐ NO ☐ YES

☐ OPHTHALMOLOGIST
☐ OPTOMETRIST
☐ OTHER:

DATE OF LAST: (1) EXAMINATION
(2) LENSES (3) FRAMES

DIAGNOSIS OR DESCRIPTION OF VISION PROBLEM:

CHECK ALL APPROPRIATE BOXES.

LENSES PRESCRIBED:

☐ SINGLE VISION
☐ BIFOCAL (SINGLE)
☐ BIFOCAL (DOUBLE)
☐ TRIFOCAL
☐ ASPHERIC
☐ LENTICULAR
☐ SUNGLASSES
☐ CONTACT

CAN PATIENT'S VISUAL ACUITY BE CORRECTED TO 20/70 OR BETTER WITH REGULAR SPECTACLE LENSES?
☐ NO ☐ YES

VISUAL ACUITY WITH SPECTACLE LENSES _____

VISUAL ACUITY WITH CONTACT LENSES _____

CHECK APPROPRIATE BOX		DESCRIPTION OF SERVICE. LIST SERVICES, MATERIALS, AND FITTINGS SEPARATELY, INCLUDING FEES. INDICATE IF TONOMETRY WAS PERFORMED.	DATE OF SERVICE			FEE
LEFT EYE	RIGHT EYE		MO.	DAY	YEAR	
						$

TOTAL CHARGES: $

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF VISION BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED ABOVE.

SIGNED (INSURED OR AUTHORIZED PERSON)

INSURED SIGNS BELOW.

I CERTIFY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, I CLAIM BENEFITS UNDER THE ABOVE GROUP PLAN AND, THEREFORE, AUTHORIZE RELEASE OF INFORMATION RELATING TO THIS CLAIM.

SIGNATURE OF INSURED | DATE

PROVIDER OF SERVICE SIGNS BELOW.

I CERTIFY THAT, WITHIN THE SCOPE OF MY LICENSE, I PERFORMED THE SERVICES LISTED ABOVE.

PROVIDER OF SERVICE | DATE