CLAIM FOR VISION CARE EXPENSE

NVA PROVIDER

ACCT #

NATIONAL VISION ADMINISTRATORS
division of National Prescription Administrators, Inc.
P.O. Box 1981 / East Hanover, N.J. 07936-1981

EMPLOYEE - Please Complete This Section *(Print)*

LAST NAME	FIRST	CARD MEMBER S.S. NO.				

COMPLETE IF CLAIM FOR DEPENDENT

STREET ADDRESS			FIRST NAME	DATE OF BIRTH	SEX	STATUS
				/ /	❒ MALE ❒ FEMALE	❒ SPOUSE ❒ CHILD
CITY	STATE	ZIP	SPONSOR NAME		MARITAL STATUS ❒ SINGLE ❒ MARRIED ❒ WIDOWED ❒ DIVORCED ❒ LEGALLY SEPARATED	

IMPORTANT, I CERTIFY THAT THE PATIENT INFORMATION ENTERED ON THIS FORM IS CORRECT, THAT THE PATIENT NAMED IS ELIGIBLE FOR THE BENEFITS AND THAT I HAVE RECEIVED THE SERVICES DESCRIBED. I ALSO CERTIFY THAT THE SERVICES AND MATERIALS RECEIVED ARE NOT FOR AN ON THE JOB INJURY OR COVERED UNDER ANOTHER VISION PROGRAM. I FURTHER AUTHORIZE THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWRITER, SPONSOR, POLICY HOLDER AND THE EMPLOYER.

❒ YES ❒ NO PLEASE REIMBURSE ME DIRECTLY.

EMPLOYEE SIGNATURE ______________________ DATE ______________

IS CLAIM CONNECTED IN ANY WAY WITH: 1) PATIENT'S OCCUPATION, ACCIDENT OR EYE SURGERY (OTHER THAN CATARACT SURGERY)? ❒ YES ❒ NO 2) SAFETY GLASSES? ❒ YES ❒ NO 3) CATARACT SURGERY? ❒ YES ❒ NO. IF ANY QUESTION ANSWERED YES, GIVE DETAILS AND DATES IN SPACE PROVIDED

TO BE COMPLETED BY EXAMINING OPHTHALMOLOGIST OR OPTOMETRIST *(Print)*

EXAMINER NAME	❒ MD ❒ OD	TAX ID#	PATIENT NAME	DATE OF EXAM
STREET ADDRESS			CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL GLASSES? ❒ YES ❒ NO	
CITY	STATE	ZIP	DID PATIENT HAVE EYEGLASSES PRIOR TO YOUR EXAMINATION? ❒ YES ❒ NO	
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES INDICATED HEREON. SIGNATURE ______	DATE ______		DOES PATIENT REQUIRE A PRESCRIPTION CHANGE? ❒ YES ❒ NO IF YES: CHANGES: AXIS ______ SPHERE OR CYLINDER ______	SERVICE CHARGE $

I HAVE PRESCRIBED ❒ SINGLE VISION ❒ BIFOCAL ❒ TRIFOCAL ❒ APHAKIC ❒ CONTACTS ❒ HARD ❒ SOFT ❒ COSMETIC ❒ MEDICALLY REQUIRED

TO BE COMPLETED BY DISPENSER *(Print)*

DISPENSER NAME		TAX ID#
STREET ADDRESS		
CITY	STATE	ZIP

I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON.

SIGNATURE ______________________ DATE ______

LENSES	U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE			
	TRADE NAME	WIDTH	❒ PAIR ❒ GLASS	❒ ONE ❒ PLASTIC
FRAMES	MANUFACTURER	SIZE	MODEL OR STYLE	
	FRAME NUMBER	❒ PLASTIC ❒ COMBINATION ❒ METAL		❒ NEW ❒ PATIENTS

PATIENT NAME					DATE OF SERVICE
Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD
RIGHT					
LEFT					

MATERIALS SUPPLIED	CHARGES	NVA USE
❒ SINGLE VISION		
❒ BIFOCAL		
❒ TRIFOCAL		
❒ APHAKIC		
❒ CONTACTS ❒ HARD ❒ SOFT		
❒ TINT# ______ COLOR ______		
❒ OTHER ______		
FRAME		
TOTAL CHARGE		

PRIOR AUTHORIZATION

NO. ______________

*** IMPORTANT ***
In Order To Guarantee Payment By NVA Please Be Sure To Include Your NVA Assigned Payment Authorization Number

PROVIDER INQUIRIES
HELP DESK
888-NVA-2020

NVA AUTHORIZATION NUMBER

MEMBER INQUIRIES
CUSTOMER SERVICE
800-672-7723