GHI OPTICAL CLAIM FORM

PLEASE TYPE OR PRINT

ALL PERTINENT PARTS OF THIS CLAIM FORM MUST BE COMPLETED.
INCOMPLETE OR INCORRECT FORMS WILL BE RETURNED.

PART A: SUBSCRIBER INFORMATION

1. SUBSCRIBER'S CERTIFICATE NUMBER | CATEGORY | GROUP

2. SUBSCRIBER'S NAME AND ADDRESS
LAST | FIRST

NO. AND STREET | APT. NO.

CITY | STATE | ZIP CODE

AREA CODE | TELEPHONE NUMBER
( )

3a. IS THE SUBSCRIBER'S SPOUSE EMPLOYED? YES ☐ NO ☐

3b. DOES THE SPOUSE OR SUBSCRIBER HAVE OTHER HEALTH INSURANCE COVERAGE? YES ☐ NO ☐

IF YOU ANSWERED YES TO EITHER QUESTION 3a. OR 3b., PART E (OTHER INSURANCE COVERAGE) ON REVERSE SIDE MUST BE COMPLETED.

4. SELF ADMINISTERED GROUP? YES ☐ NO ☐ IF YES, PART C (GROUP INFORMATION) BELOW MUST BE COMPLETED BY GROUP.

PART B: PATIENT INFORMATION

1. PATIENT'S FIRST NAME | 2. PATIENT'S DATE OF BIRTH MONTH | DAY | YEAR

3. PATIENT'S SEX AND RELATIONSHIP TO SUBSCRIBER
☐ MALE/SELF 1 ☐ FEMALE/SELF 2 ☐ HUSBAND 3 ☐ WIFE 4 ☐ SON 5 ☐ DAUGHTER 6 ☐ OTHER 7-8 SPECIFY

GHI USE ONLY

	YES	NO
4. IS PATIENT A DEPENDENT STUDENT AGE 19 OR OVER? IF YES, PART F (DEPENDENT STUDENT INFORMATION) ON THE REVERSE SIDE MUST BE COMPLETED.	☐	☐
5a. IS TEFRA APPLICABLE? (PATIENT ACTIVELY EMPLOYED, OVER 65 YEARS OF AGE)	☐	☐
5b. IS PATIENT ELIGIBLE FOR HEALTH BENEFITS UNDER MEDICARE PART B (MEDICAL)? IF YES, A COPY OF THE PATIENT'S EXPLANATION OF MEDICARE BENEFITS MUST BE ATTACHED.	☐	☐
6a. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT?	☐	☐
6b. WAS CONDITION RELATED TO AN AUTO ACCIDENT?	☐	☐
7. WAS DOCTOR NOTIFIED THAT GHI INSURES PATIENT BEFORE SERVICES WERE RENDERED?	☐	☐

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I AUTHORIZE THE RELEASE TO OR BY GHI OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

PATIENT OR AUTHORIZED SIGNATURE (PARENT OR GUARDIAN) | DATE

PART C: GROUP INFORMATION (Required ONLY if your Group Number begins with "S")

WE CERTIFY THAT THE PATIENT IS COVERED BY OUR GROUP CONTRACT AS INDICATED BY SUBSCRIBER ABOVE AND IS ELIGIBLE FOR BENEFITS.

TYPE OF CONTACT ☐ INDIVIDUAL ☐ FAMILY | DATE ELIGIBLE

BY | DATE

NAME AND ADDRESS OF GROUP (SUBSCRIBER OR GROUP SHOULD COMPLETE).

PART D: PROVIDER INFORMATION – To be completed by Nurse or Agency

VISUAL ACUITY & RX

	O.D.	O.S.
V.A. UNCOR.		
SPH.		
CYL.		
AXIS		
INT. ADD		
NEAR ADD		
PRISM		
TINT		
V.A. CORR.		

TONOMETRY YES ☐ NO ☐

DESCRIBED LENS TYPE
☐ SINGLE VISION
☐ TORIC KRYPTOK
☐ FLAT TOP 22
☐ OTHER

COMPENSATION CASE? YES ☐ NO ☐

AUTO ACCIDENT? YES ☐ NO ☐

DOES PATIENT HAVE OTHER INSURANCE? YES ☐ NO ☐

IF "YES", COMPLETE ON THE REVERSE SIDE OF THIS FORM.

LENS MFR. & BRAND NAME

FRAME NAME & MFR. OR SUPPLIER

CONTACT LENSES: ☐ HARD ☐ SOFT
☐ O.D. ONLY ☐ O.S. ONLY ☐ O.U.
DIAGNOSIS:

SERVICES RENDERED

DATE OF SERVICE

	FEE
EXAMINATION YES ☐ NO ☐	
☐ LENSES AND FRAME	
☐ LENSES ONLY	
☐ LENS ONLY	
☐ OTHER	

PRACTITIONER'S (PLEASE SHOW CORPORATE NAME, IF APPLICABLE) NAME AND ADDRESS

TAX PAYER IDENTIFYING NO. | PHONE

TOTAL FEE $ | I HAVE BEEN PAID: $

☐ I AM. ☐ I AM NOT PARTICIPATING IN A GHI PLAN

I PERSONALLY RENDERED AND COMPLETED THE SERVICES DESCRIBED: ☐ M.D. ☐ O.D. ☐ DISP. ☐ OTHER

PRACTITIONER SIGN HERE | DEGREE: | DATE

PARTICIPANTS MUST ITEMIZE ANY CHARGES MADE TO THE PATIENT:

	O.S.

IF NONE, WRITE "NONE" | TOTAL SURCHARGE $

FOR GHI USE ONLY

DIAG.	FDS	LDS	PROC	PL	PF CHG		SVC

CLAIM NO.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, *and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.*

PART E: OTHER INSURANCE COVERAGE

This part must be completed if patient is eligible for health benefits under any other health insurance policy.

EMPLOYER (SPOUSE)

EMPLOYER'S ADDRESS

CITY STATE ZIP CODE

EMPLOYER'S AREA CODE ( ) TELEPHONE NUMBER

SPOUSE'S DATE OF BIRTH MONTH DAY YEAR

NAME OF POLICYHOLDER

CERTIFICATE OR IDENTIFICATION NO. EFFECTIVE DATE OF COVERAGE

NAME OF PLAN/INSURER

PLAN/INSURER ADDRESS

PART F: DEPENDENT STUDENT INFORMATION

This part must be completed only for those having dependent student coverage if the patient is a dependent student age 19 or over. If dependent is disabled, contact your Group for special form.

I CERTIFY THAT MY DEPENDENT, _____,
MEETS ALL REQUIREMENTS FOR ELIGIBILITY AS A DEPENDENT STUDENT.

	YES	NO
A. 19 YEARS OF AGE OR OLDER	☐	☐
B. UNMARRIED	☐	☐
C. RECEIVES MORE THAN HALF OF SUPPORT FROM THE EMPLOYEE OR RETIRED EMPLOYEE	☐	☐
D. IS A FULL-TIME STUDENT AT AN ACCREDITED SECONDARY OR PREPARATORY SCHOOL OR COLLEGE	☐	☐

E. EXPECTED DATE OF GRADUATION _____

NAME OF SCHOOL

CITY

DATE STARTED IF GRADUATED, GIVE DATE

HAS DEPENDENT SERVED IN THE ARMED FORCES? ☐ YES ☐ NO
IF YES, GIVE DATES OF SERVICE.

FROM TO

SUBSCRIBER'S SIGNATURE DATE

CLAIM FILING INSTRUCTIONS: Mail this claim form promptly; follow these instructions to avoid delay.

Subscribers:

Complete the Subscriber and Patient Information sections of this claim form.

If your Group Number begins with "S," YOUR CLAIM FORM MUST BE SENT TO YOUR GROUP, NOT TO GHI.

If GHI is not your primary carrier, you must attach a copy of the payment voucher from the plan.

If your primary carrier is Medicare, you must attach the Explanation Of Medicare Benefits (EOMB).

Claims for certain specialized services should be submitted on special claim forms. These services include: nursing, drugs, optical services, and psychotherapy.

WHERE TO MAIL CLAIMS

MAIL CLAIMS TO:
GHI
P.O. Box 3000
New York, NY 10116-3000

OR THE GHI PROCESSING CENTER NEAREST YOU

GHI
P.O. Box 15030
Albany, NY 12212-5030

GHI
P.O. Box 4959
Syracuse, NY 13221-4959

GHI
P.O. Box 1570
Buffalo, NY 14205-1576

GHI
30 Corporate Woods
Suite 200
Rochester, NY 14623-1457

GHI