Bas
Benefit Administrative Systems, LLC

VISION CLAIM FORM

Receipt and itemized statement must be submitted with claim form for reimbursement

Mail Completed Form To:

The address on your

ID card under "Vision/Claims Submission"

Questions? ***Visit us @ www.BAShealth.com or call***

Members 800-843-3831

Providers 877-625-0205

EMPLOYEE & EMPLOYER INFORMATION

Employer Name: _____ **Group #:** _____ **Member ID#:**_____

Employee Name: _____ **Home Phone:** _____ **Work Phone:** _____

Employee Address:_____ **Employee Date of Birth:** / /

Employee Status: ☐ **Active** ☐ **Retired** ☐ **COBRA** ☐ **Leave of Absence**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

PATIENT AND CLAIM INFORMATION

Patient's Name: _____ **Date of Birth:** / / **Gender:** ☐ **Male** ☐ **Female**

Patient Address:_____

Patient's Relationship to the Employee: ☐ **Self** ☐ **Child** ☐ **Spouse** ☐ **Stepchild** ☐ **Other** _____

FAMILY/OTHER COVERAGE INFORMATION

Is the patient covered under any other group vision plan? ☐ **Yes** ☐ **No** **If yes, effective date of coverage:** / /

Name of policyholder _____ **Relationship to patient** _____

Name & Address of Other Vision Plan : _____

Policy#:_____ **Member ID #:**_____ **Phone #:**_____

SERVICES PROVIDED

Date of Service	Service	Amount Paid	Provider's Name / Provider's Address
	EXAM		
	CONTACT LENS FITTING/EXAM		
	CONTACT LENSES		
	FRAME		
	SINGLE VISION LENSES		
	BIFOCAL LENSES		
	TRIFOCAL LENSES		
	PROGRESSIVE LENSES (NO LINE BIFOCAL)		
	OTHER		

CERTIFICATION

I hereby authorize the release of information to BAS acquired in the course of my examination or treatment. I certify that the above information provided by me in support of this claim is complete and correct and that I am claiming benefits only for services incurred by the above named patient.

Employee's Signature _____ **Date:** / /