REIMBURSEMENT CLAIM FORM

DISTRICT EMPLOYEE VISION CARE PLAN	Quality Plan Administrators, Inc 7824 Eastern Ave NW, Ste 100 Washington DC 20012	□ Participating Provider □ Non-Participating Provider	Auth. # Auth. Date

PART A – EMPLOYEE/PATIENT INFORMATION

1. Patient Name (First Name, Middle Initial, Last Name)	2. Relationship to Employee	3. Sex M	F		4. Patient Birth Date MO	DAY	YR

5. Employee's Name (First Name, MI, Last Name)	6. Employee SS# or Vision Plan ID#	7. Home Phone # Work Phone#

8. Employee Mailing Address, City, State, Zip Code	9. If patient is full time student give Name of School Date of Present Term from To

10. Control #:	11. Employer	12. Were these services required due to a work injury or condition □ Yes □ No

13. SIGNED: I Authorize the Release of any Information Necessary to Process this request. I certify the information furnished by me in support of this request is true and correct.	14. Is this exam or glasses covered under a company safety glass program? □ Yes □ No Yes, indicate which: □ exam □ lenses □ frames Are you or your dependents entitled to benefits under any other insurance plan? Yes_____ No _____ If yes, from whom
_____ _____ (SIGNATURE OF EMPLOYEE) (DATE) _____ _____ (SIGNATURE OF PATIENT OR GUARDIAN) (DATE)	

PART B - EXAMINING PHYSICIAN (check one): **□ Optometrist** **□ Ophthalmologist**

15. Indicate Diagnosis or Nature of Disease or Injury or Vision Disorder If contact lenses prescribed, indicate

__Cosmetic ___Visual acuity is not correctable with ophthalmic lens to 20/70 in better eye

16.		SPHERE	CYLINDER	AXIS	PRISM	ADD BIFOCAL	ADD TRIFOCAL	VISUAL ACUITY DIST.	VISUAL ACUITY READING
PRESCRIPTION	R								
	L								

17. Was lens change required Yes □ No □ If yes, do new lenses differ from the most recent prescription (or in absence of a previous prescription (by an axis change to 20 diopter or .50 diopter cyclinder change and do lenses improve visual acuity by at least one line on standard chart?

□ Yes □ No

18. Report of service (or attach itemized bill)

DATE OF SERVICE	SERVICE RENDERED	
	□ Exam	□ Glaucoma

19. Provider's Name, Address, City, State, Zip Code .	20. Telephone Number:	21: Provider TIN*:
	22.: Total Exam Charge:	23. Amount Paid:
24. PROVIDER SIGNATURE 25. DATE		26. Balance Due:

PART C – SUPPLIER INFORMATION (TO BE COMPLETED BY DISPENSER OF PRESCRIPTION)

27. LENSES □ One Eye □ Both Eyes □ Glass □ Plastic □ Other

Date Material Ordered _____
Date Delivered _____

Charged: Single Vision $_____ Lenticular $_____ Bifocal $_____ Contact Lenses $_____ Trifocal $_____ Other $_____ $_____

28. Describe and indicate additional charges for special features such as:

□ Tinting (more than ting #1 and #2) $_____ □ Aphakic $_____ □ Oversized lenses $_____ □ Progressive lenses $_____

□ OTHER (Specify)

29-a. FRAMES	29-b. FRAMES	
□ From Pre-Approved Selection - $20	$_____ Cost	30. Charge for lenses:
□ Not from Pre-Approved Selection	$20.00 Less Plan Frame Allowance	31. Charge for frame:
(If "Not from Pre-Approved Selection" fill out 29-b)	$ Patient Co-Payment	32. Total Charge:

33. Signature of Supplier	34. Date Signed	35. Amount Paid:
		36. Balance Due:

Additional Instructions on Page 2

Important Information

Prompt Reimbursement

TO FACILITATE CLAIM REIMBURSEMENT IN A TIMELY MANNER, PLEASE ADHERE TO THE FOLLOWING GUIDELINES AND BE AWARE THAT:

A) The Claim form is filled out completely, ie. date(s) of service, applicable procedures/codes, provider's signature, etc.

B) The claim must be submitted to QPA within 180 days of service, or it will be denied.

C) The claim must represent actual services **already** rendered.

D) An itemized paid receipt **must** be attached.

E) Any denial of a claim can be appealed.

F) Any appeal must be filed, in writing within 60 days of notification to you.

*TIN = Taxpayer Identification Number

Please send all completed claims to:

Quality Plan Administrators, Inc
7824 Eastern Avenue NW
Suite 100
Washington DC 20012