CORESOURCE
A Trustmark Company

VISION CLAIM FORM

INSTRUCTIONS FOR COMPLETING FORM:

- **COMPLETE PART A, BEING SURE TO SIGN AND DATE THE FORM IN EACH OF THE APPROPRIATE SPACES.**
- **HAVE YOUR DOCTOR COMPLETE PART B OR ATTACH AN ITEMIZED BILL.**
- **HAVE PERSON FILLING PRESCRIPTION COMPLETE PART C.**
- **SEND CLAIM TO ADDRESS LISTED BELOW.**

PART A **TO BE COMPLETED BY EMPLOYEE (ANSWER ALL QUESTIONS TO AVOID DELAY)**

1. Name of Employee (Print last name first) 2. Home Address	4. Employee's ID #
3. Claim is made for MYSELF ☐ SPOUSE ☐ CHILD ☐ Patient's name (if other than self) Patient's Date of Birth / / Patient's Occupation. If Student, give Name and Address of School	5. A. Is your spouse/dependent employed? YES ☐ NO ☐ If yes, give: B. Spouse Name: C. Employer Name: D. Employer Address:
6. Do you, your spouse or children have coverage under any vision plan other than with this plan? YES ☐ NO ☐ A. If "Yes", give name of other Insurance company(ies) and claim office address	B. Is this coverage provided on a group ☐ or individual ☐ basis? C. Name and address of employer, union, school or organization through which this coverage is arranged.

7. EMPLOYER'S NAME **COOPER UNION FOR THE ADVANCEMENT OF SCIENCE & ART**	8. GROUP NUMBER **CN**

9. I certify that the above statements and answers, including any accompanying bills and statements are true and complete to the best of my knowledge and belief. I authorize the release to and the use by CORESOURCE of any medical or other information needed in processing this claim. A photocopy of this authorization shall be as valid as the original.

Date Signature of Employee

Please mail Claim Statement to:

CoreSource, Inc.
P.O. Box 2920
Clinton, IA 52733-2920
Telephone: 1-800-624-7130

PART B **EXAMINING OPHTHALMOLOGIST'S OR OPTOMETRIST'S STATEMENT**

Diagnosis on Nature of Disease, Injury or Vision Disorder

Is Condition due to Injury or Sickness arising out of patient's employment?

☐ YES ☐ NO If yes, explain.

Report of Service (Or attach itemized bill)

DATE OF SERVICES	SERVICES RENDERED	CHARGES

Fee For:

LENSES $_____ TOTAL CHARGES _____ BALANCE DUE

FRAMES $_____

CONTACTS $_____ AMOUNT PAID _____ _____

Did patient have glasses prior to this examination?

☐ YES ☐ NO IF YES, WHAT TYPE? ☐ LENSES IN FRAMES ☐ HARD CONTACTS ☐ SOFT CONTACTS

Does patient require a lens prescription change at this time? **Are new frames required?**

☐ YES ☐ NO IF YES, WHY? ☐ YES ☐ NO

MATERIALS PRESCRIBED (Check appropriate box(es) and indicate number prescribed)

☐ FRAMES _____ ☐ BIFOCAL _____ ☐ CONTACT LENSES HARD _____ SOFT _____

☐ SINGLE VISION _____ ☐ TRIFOCAL _____ ☐ OTHER _____

If Tinted Lenses, Sunglasses and/or Safety Glasses prescribed, please explain.

Date	**Type or Print Full Name**	**Degree**	INDIVIDUAL PRACTIONERS SS#
Provider's Signature		**Telephone**	ALL OTHERS – EMPLOYER I.D.#

Must be furnished under Authority of Law

Street Address **City of Town** **State** **Zip Code**

PART C

TO BE COMPLETED BY DISPENSER OF PRESCRIPTION – IF DIFFERENT FROM EXAMINING DOCTOR

(Or Attach Itemized Statement)

Date of Delivery	**Fee For:** LENSES $_____ FRAMES $_____ CONTACTS $_____

Type or Print Full Name		INDIVIDUAL PRACTIONERS SS#
Dispenser's Signature	**Telephone**	ALL OTHERS – EMPLOYER I.D.#

Must be furnished under Authority of Law

Street Address **City or Town** **State** **Zip Code**