CLAIM FOR VISION CARE EXPENSE

NATIONAL VISION ADMINISTRATORS, L.L.C.
P.O. BOX 2187 / CLIFTON, NEW JERSEY 07015
1- 800-672-7723 / www.e-nva.com

Montgomery County Government

TO BE COMPLETED BY EMPLOYEE (Print)										
LAST NAME FIRST	CARD MEMBER SOC SEC NUM									
STREET ADDRESS	COMPLETE IF CLAIM IS FOR DEPENDENT									
	FIRST NAME	DATE OF BIRTH	GENDER	STATUS						
		/ /	MALE □ FEMALE □	SPOUSE □ CHILD □						
CITY STATE ZIP CODE	MARITAL STATUS □SINGLE □MARRIED □WIDOWED □DIVORCED □LEGALLY SEPARATED									

I HEREBY 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 AUTHROIZE THE RELEASE OF ALL INFORMATION ON THIS FORM TO NVA, UNDERWITER, SPONSOR, POLICY HOLDER AND THE EMPLOYER.

EMPLOYEE'S 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 THE SPACE PROVIDED.

IS PATIENT COVERED UNDER ANY OTHER GROUP VISION PLAN FOR THE SERVICE(S) PRESENTED BELOW? □ YES □ NO IF ANSWERED YES, GIVE INSURANCE COMPANY NAME, ADDRESS AND POLICY NUMBER IN THE 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 EYEGLASSES? □YES □NO			
CITY STATE ZIP CODE	DOES 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/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#				PATIENT NAME					DATE OF SERVICE	
STREET ADDRESS				Rx	SPHERE	CYLINDER	AXIS	PRISM	ADD	
CITY STATE ZIP CODE				RIGHT						
				LEFT						
I HEREBY CERTIFY THAT I HAVE RENDERED THE SERVICES AND SUPPLIED THE MATERIAL INDICATED HEREON. SIGNATURE DATE				MATERIALS SUPPLIED		CHARGES		NVA USE		
LENSES	U.S. MANUFACTURER NAME, FABRICATING LAB MODEL OR STYLE			□SINGLE VISION						
				□BIFOCAL						
				□TRIFOCAL						
	TRADE NAME WIDTH	□PAIR	□ONE	□APHAKIC						
		□GLASS	□PLASTIC	□CONTACTS						
				□HARD	□SOFT					
FRAMES	MANUFACTURER NAME SIZE		MODEL OR STYLE	□TINT #:	COLOR:					
				□OTHER						
	FRAME NUMBER □PLASTIC	□METAL	□NEW	**FRAME**						
		□COMBINATION	□PATIENT'S	**TOTAL CHARGE**						

CLAIM INSTRUCTIONS

EMPLOYEE:

- Use this form to obtain reimbursement for services.
- Complete the employee section of the form.
- Sign and date the form after checking for completeness.
- Attach copy of itemized receipts.
- Claim must be received by National Vision Administrators within 12 months of the date of service
- Scan and submit the form by email to: visionclaims@e-nva.com
- Submit the form by fax to: 973-574-2430
- Submit the form by mail to:

  National Vision Administrators, L.L.C.
  P.O. Box 2187
  Clifton, New Jersey 07015

- If you have any questions, please contact NVA at 800-672-7723.