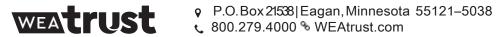


Essential Vision Plan Claim Form

National Vision Administrators manages the Essential Vision Plan on behalf of the WEA Trust.

OUT OF NETWORK VISION CARE CLAIM FORM INSTRUCTIONS

- Use this form to obtain reimbursements for services
- Part A to be completed by Employee
- Part B to be completed by your Eye Care Professional (Option)
- Part C to be completed by your Eyewear Dispenser
 - Submit the form by mail to: National Vision Administrators, L.L.C. P.O. Box 2187 Clifton, New Jersey, 07015
- Include a copy of your receipts with your completed vision care claim form
- If you have any questions, please contact NVA at (877) 262-7915



DIF	ASE P	DIVID	INFO	PMAT	ΓΙΩΝΙ							Ε	SS	ential	Vision	Plar	Clai	m Fo	rm	
						D RV	/ EMI	PI C	YEE											
PART A: TO BE COMPLETED BY EMPLOYEE 1. EMPLOYEE'S NAME (LAST, FIRST, MIDDLE)												2. EMPLOYEE'S ADDRESS (No., Street, City, State, Zip Code)								
3. EMPLOYER'S IDENTIFICATION #											4. EI	4. EMPLOYEE'S TELEPHONE #								
5. EMPLOYER'S NAME												6. EMPLOYER'S ADDRESS (No., Street, City, State, Zip Code)								
7. PATIENT'S NAME (LAST, FIRST, MIDDLE)									3. PATIE	NT'S R	ELATION	ATIONSHIP TO EMPLOYEE				9. PATIENT'S GENDER			LO. PATIENT'S PATE OF BIRTH	
									SELF CHILD)	□ STUDENT		DENT	□ MALE				
Γ									SPOUSE HANDICAF			ICAPP	ED	□ OTHER		□ FI	□ FEMALE			
_	PATIEN HER VIS			Υ	YES NO			١	VISION PLAN NAME				GROUP#		IAN	NAME AND ADDRESS OF CARRIER				
															an application					
	-	•							•	•		_			oncerning any	fact m	aterial the	ereto co	mmits a	
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1. DOCTOR'S NAME (LAST, FIRST, MIDDLE)								2. TAX PAYER IDENTIFICAT								INESS PHONE # (area code)				
4. TITLE:									5. DO	5. DOCTOR'S ADDRESS (No., Street, City, State, Zip Code)										
6. PROFESSIONAL SERVICE					7. AMOUNT				8. EXAMINATION DATE 9. WAS CATARACT PERFORMED?							RGERY □ Y		□ YES	□NO	
EYE EXAMINATION					\$				10. CAN VISUAL ACUITY BE RESTORED TO 20 CONVENTION EYEGLASSES?					20/70 IN BET	TER EY	E WITH	□ YES	□NO		
CONTACT LENS EXAM (if any)					\$								IRE A PRESCRIPTION CHANGE AT THIS			S TIME?	□ YES	□NO		
	UNT PA		•							12. DIAGNOSTIC CODE(s)										
13. IN	DICATE	DIAG	NOSIS C	R NATI	JRE OF	DISE	ASE, IN	JURY		VISION DISORDER. CODE #'S INDICATE PROCEDURE						14.	14. VISUAL ACUITY CORRECTED TO:			
15. D	octor's I	Prescr	ption							16. I hereby certify th					rtify that I hav	t I have performed the services as indicated				
			•		,								heron.							
SPHERE				C,	CYLINDER AXIS				PRISM	BASE										
R.E.					•															
L.E.	L.E. READING ADD				• R.E. +•				L.E.				DOCTOR'S SIGNATURE					D.4		
												+ ● DOCTOR'S SIGNATURE DATE							IE	
	PART C: TO BE COMPLETED BY DISPENSE 1. DISPENSER'S NAME (LAST, FIRST, MIDDLE)											2. TAX PAYER IDENTIF				N #				
3. DIS	3. DISPENSER'S ADDRESS (No., Street, City, State, Zip Code)												4. BUSINESS PHONE # (area code)							
5. PR	DEESSIO	ΝΑΙ ς	FRVICE	<u> </u>								I								
													, SERVICES, OR DIAGN DIAGN COL			S \$ CHARGES		GES	DAYS OR UNITS	
SERVICE									circumstances)											
FROM T										CPT/	HCPC	МО	DIFII	ER						
MM	DD	YY	MM	DD	YY							1								

6. PATIENT'S ACCOUNT # 7. TOTAL CHARGED 8. AMOUNT PAID 9. BALANCE DUE

10. I hereby certify that I have performed the services as indicated hereon.

DISPENSER'S SIGNATURE

DATE