WEA trust
P.O. Box 2138 | Eagan, Minnesota 55121–5038
800.279.4000 WEAtrust.com

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

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Essential Vision Plan Claim Form

PLEASE PRINT INFORMATION

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. EMPLOYEE'S TELEPHONE #
5. EMPLOYER'S NAME	6. EMPLOYER'S ADDRESS (No., Street, City, State, Zip Code)

7. PATIENT'S NAME (LAST, FIRST, MIDDLE)	8. PATIENT'S RELATIONSHIP TO EMPLOYEE			9. PATIENT'S GENDER	10. PATIENT'S DATE OF BIRTH
	□ SELF	□ CHILD	□ STUDENT	□ MALE	
	□ SPOUSE	□ HANDICAPPED	□ OTHER _____	□ FEMALE	

11. IS PATIENT COVERED BY ANOTHER VISION PLAN?	□ YES	□ NO	VISION PLAN NAME	GROUP #	NAME AND ADDRESS OF CARRIER

12. Anyone who knowingly and with intent to defraud any insurance company or other person; files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties.

PART B: TO BE COMPLETED BY EYE CARE PROFESSIONAL (OPTIONAL)

1. DOCTOR'S NAME (LAST, FIRST, MIDDLE)	2. TAX PAYER IDENTIFICATION #	3. BUSINESS PHONE # (area code)

4. TITLE:	□ MD	□ DO	□ OD	5. DOCTOR'S ADDRESS (No., Street, City, State, Zip Code)

6. PROFESSIONAL SERVICE	7. AMOUNT	8. EXAMINATION DATE	9. WAS CATARACT SURGERY PERFORMED?	□ YES	□NO
EYE EXAMINATION	$	10. CAN VISUAL ACUITY BE RESTORED TO 20/70 IN BETTER EYE WITH CONVENTION EYEGLASSES?		□ YES	□NO
CONTACT LENS EXAM (if any)	$	11. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME?		□ YES	□NO
AMOUNT PAID BY PATIENT	$	12. DIAGNOSTIC CODE(s)			

13. INDICATE DIAGNOSIS OR NATURE OF DISEASE, INJURY, VISION DISORDER. CODE #'S INDICATE PROCEDURE	14. VISUAL ACUITY CORRECTED TO:

15. Doctor's Prescription						16. I hereby certify that I have performed the services as indicated heron.	
SPHERE		CYLINDER	AXIS	PRISM	BASE		
R.E.		●					
L.E.		●					
READING ADD		R.E.	+ ●	L.E.	+ ●	DOCTOR'S SIGNATURE	DATE

PART C: TO BE COMPLETED BY DISPENSER

1. DISPENSER'S NAME (LAST, FIRST, MIDDLE)	2. TAX PAYER IDENTIFICATION #
3. DISPENSER'S ADDRESS (No., Street, City, State, Zip Code)	4. BUSINESS PHONE # (area code)

5. PROFESSIONAL SERVICES

DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPC	MODIFIER		DIAGNOSIS CODE	$ CHARGES		DAYS OR UNITS

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