

**Please complete this
Form in blue or black ink.**



**MAIL ALL CLAIMS TO:
GREAT-WEST HEALTHCARE
1000 GREAT-WEST DRIVE
KENNETT, MO 63857-3749**

VISION STATEMENT OF CLAIM

1. Employee Name		2. Sex <input type="checkbox"/> M <input type="checkbox"/> F		3. Date of Birth MM DD YY		4. SSN	
5 a. Employee Address Street			b. City		c. State		d. Zip Code
6. Employer's Name			7. Group Policy or Control #			8. Phone Number	
9. Patient Name			10. Patient Birthdate MM DD YY		11. Patient Relationship to Insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		
12 a. If child is 19 or over <u>and</u> a Full-time student give name and Address of school:							
b. For Full-time student check appropriate box: <input type="checkbox"/> 19-22 <input type="checkbox"/> 19-23 <input type="checkbox"/> 19-25							
13 a. Are natural parents divorced or separated? <input type="checkbox"/> Yes <input type="checkbox"/> No			b. Do you have custody? <input type="checkbox"/> Yes <input type="checkbox"/> No		c. Do you have court ordered financial responsibility for Health Expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		
14. Was the patient covered by another Group Health Plan, Medicare or other governmental plan at the time the charges were incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No				15. Name of other Insurance Company			
16. Name of person covered by other Insurance?			17. Other Insured Sex <input type="checkbox"/> M <input type="checkbox"/> F		18. Date of Birth MM DD YY		19. SSN
20. Name of other Insured's Employer			21. Group ID or policy number		22. Employer phone number		
23. Reason for Claim <input type="checkbox"/> Illness <input type="checkbox"/> Accident		24. If "Accident" please provide date, place and how it happened					
25. Was condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		a. Date		b. Place		c. How Accident happened	
26. Patient's Or Authorized Person's Signature. I authorize the release of any medical or other information necessary to process this claim. NOTICE: See generic and state specific Anti-Fraud requirements on reverse side of this form. Signature _____ Date _____					27. Insured's or Authorized Person's Signature I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Authorization Does Not Extend To Benefits Payable For Services Completed After This Form is Released By Provider. Signed _____ Date _____		
28. Physician or Supplier Name				Degree		29. Area Code and Phone Number	
30 a. Physician Mailing address (street)						31. Physician or Supplier Tax ID	
b. City		c. State		d. Zip Code		32. Physician or Supplier SSN	
33. Were services related to a medical or surgical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			34. If contact lenses were prescribed, were the lenses prescribed following surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No			35. Dates patient unable to perform regular and customary work	
36. Diagnosis or Nature of Injury						MM DD YY	
1.			3.			from: MM DD YY	
2.			4.			to: MM DD YY	
37. Description of Service				Number of Lenses Purchased		Date Service Performed	
a. Complete Examination							
b. Lenses (Give Type) <input type="checkbox"/> Single-Vision <input type="checkbox"/> Tri-focal <input type="checkbox"/> Contact <input type="checkbox"/> Bi-Focal <input type="checkbox"/> Lenticular <input type="checkbox"/> Other							
c. Frames							
d. Other Services							
I hereby certify that the services and charges as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.						Total Amount Charged	
						Amount Paid on Total Charged	
Signed by Physician or Supplier				Date			

Great-West Healthcare refers to products and services provided by Great-West Life & Annuity Insurance Company and its subsidiaries (Alta Health & Life Insurance Company and Great-West Healthcare HMO/HCSC companies). It also refers to the group business that is underwritten by New England Life Insurance Company and Metropolitan Life Insurance Company which is currently administered by Great-West Life & Annuity Insurance Company. Great-West Life & Annuity Insurance Company is not licensed to do business in New York. Products are sold in New York by its subsidiary First Great-West Life & Annuity Insurance Company, White Plains, N.Y.

FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is guilty of criminal and/or civil offense. This notice does not apply in VA. For the states of AZ, CA, FL, ID, NM, OR, PA, TN and TX, please refer to the following fraud notices:

Arizona Fraud Notice:

Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Fraud Notice:

For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Florida Fraud Notice:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho Fraud Notice:

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

New Mexico Fraud Notice:

All claim forms and applications for insurance must contain the following disclosure:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Oregon Fraud Notice:

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any materially false, incomplete or misleading information maybe guilty of insurance fraud.

Pennsylvania Fraud Notice:

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

Tennessee Fraud Notice:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Fraud Notice:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.