Benefit Administrators, Inc.

SEND TO: **Attention: VISION CLAIMS Department**
BENEFIT ADMINISTRATORS, INC.
1250 TOWER LANE
P O BOX 6279
ERIE PA 16512-6279
(814) 454-0167 or (800) 777-2524 ***BAI@HBKW.NET***

VISION BENEFITS CLAIM FORM

(PART A) TO BE COMPLETED BY EMPLOYEE

Name of Employee	Social Security # :	Name of Employer

Employee Address	City and State	Zipcode	Date of Birth

Patient's Full Name	Relation to Employee	Date of Birth	Is this Claim Related to an Injury?
			☐ Yes ☐ No

Is the Patient Covered by any Other Vision Insurance Plan? Yes ☐ or No ☐	If Yes, Give Name of Carrier, Carrier Address, Group Number and Covered Identification Number:

AUTHORIZATION TO RELEASE INFORMATION: I authorize the benefits payable for this claim to be paid directly to the provider in **Part B of this form**, otherwise payable to me. I acknowledge that this claim is not for the treatment of any occupational accident or third party injury and I hereby authorize any of the undersigned to disclose any necessary information related to the processing of this claim.

Signature of Employee _____ Date _____

(PART B) TO BE COMPLETED BY OPTOMETRIST, OPTHALMOLOGIST, OPTICIAN (PLEASE PRINT)

Diagnosis:

DATE OF SERVICE	Procedure Code (CPT or HCPS)	DESCRIPTION	AMOUNT CHARGED

Name and Address of Provider of Services:	Tax Id Number:	Phone Number:

Providers Signature : _____ **Date :** _____