NORTHWEST BENEFIT NETWORK – VISION PLAN

ELIGIBILITY AUTHORIZATION # ______

NAME OF GROUP ______ **PLAN #** ______

EMPLOYEE INFORMATION

FIRST NAME | LAST NAME | DATE OF BIRTH | SPOUSE'S DATE OF BIRTH

STREET ADDRESS | CITY | ST | ZIP | HOME PHONE

SOCIAL SECURITY NO. | NAME OF EMPLOYER | LOCAL UNION

PATIENT INFORMATION

THIS CLAIM IS FOR
- SELF ☐
- SPOUSE ☐
- DOMESTIC PARTNER ☐
- CHILD ☐
- STEP-CHILD ☐
- OTHER ______ ☐

FIRST NAME | LAST NAME | DATE OF BIRTH | MALE ☐ FEMALE ☐

IS THE PATIENT A FULL TIME STUDENT? YES ☐ NO ☐ If Yes, all information in the shaded box is **REQUIRED**

NAME OF SCHOOL CURRENTLY ATTENDING ______

LAST 4 QUARTERS ATTENDED FALL YR ______ WINTER YR ______ SPRING YR ______ SUMMER YR ______

IF NOT ATTENDING SUMMER QUARTER, IS PATIENT ENROLLED FOR COMING FALL QUARTER? ☐ YES ☐ NO

IF NO, WHEN WAS LAST DAY ATTENDED? MONTH ______ YEAR ______

OTHER COVERAGE INFORMATION (COMPLETION OF THIS SECTION IS REQUIRED)

DOES THE PATIENT HAVE OTHER VISION COVERAGE ☐ YES ☐ NO

______ IF YES, NAME OF PERSON WITH OTHER VISION COVERAGE | ______ THEIR RELATIONSHIP TO THE PATIENT | ______ DATE OF BIRTH | ______ SOCIAL SECURITY NO.

______ IF YES, NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THESE SERVICES | ______ POLICY NUMBER

WAS VISION CARE REQUIRED BECAUSE OF AN INJURY? ☐ YES ☐ NO IF YES, ANSWER QUESTIONS BELOW

WAS INJURY CAUSED BY YOUR WORK? ☐ YES ☐ NO | HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKERS COMPENSATION CARRIER? ☐ YES ☐ NO | IS VISION REQUIRED AS A CONDITION OF YOUR EMPLOYMENT? ☐ YES ☐ NO

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE TO FURNISH AND DISCLOSE ALL FACTS CONCERNING THIS CLAIM. I AGREE THAT, IF MY PLAN DOES NOT PROVIDE COVERAGE FOR THE EXPENSES INCURRED OR I AM NOT ELIGIBLE FOR BENEFITS, I WILL BE RESPONSIBLE FOR PAYMENT OF ALL CHARGES.

______ DATE ______ EMPLOYEE'S SIGNATURE

* NOTE TO *
* PROVIDERS *

THE LOWER PORTION OF THIS CLAIM MUST BE COMPLETED BY THE ATTENDING PANEL PROVIDER

IF YOU ARE NOT AN NBN PANEL PROVIDER, PLEASE PROVIDE THE PATIENT WITH AN ITEMIZED BILL. YOU DO NOT NEED TO COMPLETE THIS CLAIM FORM.

NAME OF PROVIDER TO BE PAID | DEGREE(S)

OFFICE ADDRESS | TAX ID NUMBER | PROVIDER'S NBN NUMBER

CITY | ST | ZIP | DATE SERVICES BEGAN | DATE SERVICES COMPLETED

I hereby certify that I personally performed the professional services and have billed NBN no more than my usual and customary fee

Signature of Attending Provider ______ Date ______

EXAMINATION	EXAM FEE	LENS	LENS COST
COMPREHENSIVE ☐ INTERMEDIATE ☐ LIMITED ☐		SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐ PROGRESSIVE ☐ OTHER ______ ☐ ☐ GLASS ☐ PLASTIC	
CONTACT LENS	**CONTACT EXAM FEE**	**CONTACT LENS**	**CONTACTS COST**
EVALUATION/FITTING ☐		DISPOSABLE ☐ STANDARD ☐ GAS PERMEABLE / HARD ☐	
SUBNORMAL VISION AID			
CONTACT LENS PRIOR AUTHORIZATION REQUIRED ☐			
		FRAMES	**FRAMES COST**
		PATIENT'S FRAME ☐ NEW FRAME ☐ IF NEW FRAME, BELOW IS **REQUIRED**	
		NAME	
		STYLE	
		MANUFACTURER	
		TAX RATE %	TOTAL $

PLEASE SEND COMPLETED AND SIGNED NBN COPY TO:

NORTHWEST BENEFITS NETWORK
2323 EASTLAKE AVENUE EAST, SEATTLE, WA 98102
(206) 726-3278 (800) 732-1123 WWW.NWADMIN.COM

PROVIDER, PLEASE RETAIN THE DOCTOR COPY FOR YOUR RECORDS.
LAB COPY SHOULD ONLY BE SENT TO AN NBN APPROVED LAB.

NBN COPY ☐ LAB COPY ☐ **PROVIDER COPY** ☐

DEPENDENT CHILD QUESTIONNAIRE

Please complete this form if the patient is 1) a natural child who does not reside with the employee, 2) stepchild, 3) a grandchild, or 4) a child for whom you have been appointed legal guardian.

1. Name of Employee ______________________ Soc. Sec. No. ______________

2. Name of Dependent Child ______________________
   a) Relationship to Employee ______________________
   b) Date of Birth ______________________

3. Does the Employee contribute 50% or more of the child's yearly support? Yes ☐ No ☐

4. Do you claim this child as an exemption on your income tax return? Yes ☐ No ☐

5. Does the child reside in the Employee's home? Yes ☐ No ☐
   a) On what date did the child become a member of the Employee's household ______________

6. Does the Employee have legal custody of the child? Yes ☐ No ☐

7. Is there any other Vision coverage through Group Insurance which would cover the child? Yes ☐ No ☐
   a) Please provide the name and Social Security number of the Insured

   (name) ______________________ (SSN) ______________

   b) What is the name and address of the Insurance Company: (name) ______________________

   (address) ______________________

I hereby certify that the statements are correct and show the true circumstances of the person named.

______________________ (Signature of Employee) ______________ Date

---

AGREEMENT FOR ADDITIONAL MATERIALS, EXTRAS, OR SERVICES NOT COVERED BY THE PLAN

ITEM	Amount
Deductible	$
Frames – Excess Over Allowance	$
	$
	$
	$
TOTAL	$

I understand that I am financially responsible for the additional charges listed above.

______________________ Patient's Signature ______________ Date