GROUP VISION CLAIM FORM

HealthComp
Third Party Administrators

SUBMIT CLAIMS TO: P.O. BOX 45018, FRESNO, CA (800) 442-7247

1. Your Policy and/or Group number(s)
G45

2. Name and address of employer
RMS 8530 La Mesa Blvd #200 La Mesa, CA 91942

EMPLOYEE INFORMATION

3. Name of employee *(insured)*	☐ Male ☐ Female	Date of Birth	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

4. Address of employee Street City State Zip Code	5. Employee's Social Security number

6. Other Vision Insurance Coverage? ☐ Yes ☐ No If yes, please provide name of employer and address of Insurance Company

IF CLAIM FOR DEPENDENT, COMPLETE THIS SECTION ALSO

7. Name of your dependent	☐ Male ☐ Female	Date of Birth	Is dependent a full-time student? ☐ Yes ☐ No

COMPLETE FOR VISION SERVICES OR ATTACH ITEMIZED BILL

8. Date of Service	Services Rendered	Charge

9. Physician or Optometrist Name	Address Street City State Zip Code
10. Tax ID Number	11. Signature of Physician or Optometrist Date Signed

COMPLETE FOR VISION SUPPLIES OR ATTACH ITEMIZED BILL

12. LENSES: ☐ One Eye ☐ Both Eyes
Charge:_____ ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Other _____

13. FRAMES: Charge:_____	14. Are existing Frames being used for new lenses? ☐ Yes ☐ No If No, Why?
15. Suppliers Name	Address Street City State Zip Code
16. Tax ID Number	17. Signature of Supplier Date Signed

IMPORTANT – PLEASE COMPLETE AUTHORIZATION SECTION

18. AUTHORIZATION TO RELEASE INFORMATION:
The above answers are true and correct to the best of my knowledge. I hereby authorized any physician, surgeon, practitioner or other person, any hospital, including veterans administration or government hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A Photostat of this authorization shall be as valid as the original.

Signed (Patient or Parent if Minor) Date

19. AUTHORIZATION TO PAY INSURANCE BENEFITS:
I hereby authorize payment directly to the Physician named above those benefits otherwise payable to me but not to exceed the Physician's regular charges. I understand I am financially responsible to the Physician for charges not covered by this authorization.

Signed (Patient or Parent if Minor) Date

Please attach itemized bills to this form and mail to : HEALTHCOMP, INC.

HealthComp
Third Party Administrators

Dental Claim Form

Check one:
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

PATIENT COVERAGE

1. Patient Name (First, MI, Last)	2. Relationship to employee	3. Sex	4. Patient birth date (MM DD YYYY)	5. If full-time student (School, City)
	☐ self ☐ child ☐ spouse ☐ other_____	☐ male ☐ female		

6. Employee /subscriber name and mailing address	7. Employee Soc. sec. or I.D. number	8. Employee birthdate (MM DD YYYY)	9. Employer name an address	10. Group number
			RMS LA MESA, CA	G45

11. Is patient covered by another dental plan? ☐ yes ☐ no If yes complete 12-a. Is patient covered by a medical plan? ☐ yes ☐ no	12-a Name and address of carrier(s)	12-b Group no(s)	13. Name and address of other employer(s)

14.-a Employee bane (if different than patient's)	14-b Employee Soc. sec. or I.D. number	14-c Employee birthdate (MM DD YYYY)	15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other_____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

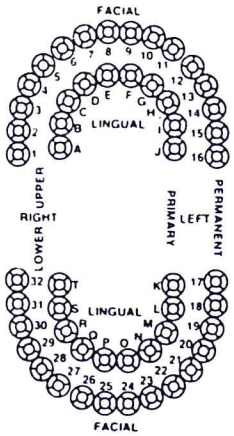
Signed (Patient or parent if minor) _____ Date _____

I hereby authorize payment of the dental benefits otherwise parable to me directly to the below named dental entity.

Signed (Insured person) _____ Date _____

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
17. Address where payment should be remitted	25. Is treatment result of auto accident?			
City State Zip	26. Other accident?			
18. 19. 20.	27. If prosthesis, is this initial placement?			(If no, reason for replacement) 28. Date of prior placement
21. First visit date current series	22. Place of treatment: Office, Hosp, ECF, Other	23. Radiographs or models enclosed? No Yes How many?	29. Is treatment for orthodontics?	If services already Commenced enter; Date appliances placed; Mos. treatment remaining



30. Examination and treatment plan – List in order from tooth no 1 through tooth no 32 – Use charting system shown

Tooth # or letter	Surface	Description of service (Including x-rays, prophylaxis, materials used, etc.)	Date of Service Performed Mo Day Year	Procedure Number	Fee	For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures 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.

Signed (Treating Dentist) _____ License Number _____ Date _____

Total Fee Charged	
Max Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

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