Northwest Benefit Network — Vision Plan

Eligibility Authorization #

Plan # **AN**

Name of Group **GRAYS HARBOR COUNTY SCHOOL DISTRICT'S VISION PLAN**

FIRST-PAIR ☐ SECOND PAIR ☐

Employee's Social Security No. | Name of Employer | Local Union

Employee's Name (First) (Last) | Employee's Date of Birth | Spouse's Date of Birth

Employee's Address and Phone — City — State — Zip Code — Home Phone #

Claim is for: ☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other

NAME OF PATIENT ***Please See Back of First Page.** (First) (Last) | ☐ MALE ☐ FEMALE | DATE OF BIRTH

IS PATIENT A FULL-TIME STUDENT? ☐ YES ☐ NO

IF YES, NAME OF SCHOOL CURRENTLY ATTENDING — For_____ Quarter of 20_____

STUDENT IS UNMARRIED & DEPENDS UPON ME FOR SUPPORT ☐ YES ☐ NO

* Please see reverse side of this form for Dependent Child Eligibility Questionnaire.

SPOUSE'S NAME | NAME AND ADDRESS OF SPOUSE'S EMPLOYER | SPOUSE'S SOCIAL SECURITY NUMBER | **DOES SPOUSE HAVE OTHER VISION INSURANCE?** ☐ YES ☐ NO

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, complete 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 EXAMINATION 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 employer 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 Fully 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 | Tax ID Number

Address | Provider's NBN Number

City, State Zip Code | 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

EXAMINATION	EXAM FEE	LENS	LENS COST
Comprehensive ☐		Single Vision ☐	
Intermediate ☐		Bifocal ☐	
Limited ☐		Trifocal ☐	
		Lenticular ☐	
		Progressive ☐	
		GLASS ☐ PLASTIC ☐	

MATERIALS SERVICES	DISPENSING FEE	CONTACT LENS	CONTACTS COST
Did you Prescribe? Yes ☐ No ☐		Elective Contact Lenses ☐	
		Subnormal Vision Aid PAIR ☐	
		Subnormal Vision RIGHT LENS ☐	
		Subnormal Vision LEFT LENS ☐	

MATERIALS SERVICES		FRAMES	FRAMES COST
Did you Dispense? Yes ☐ No ☐		New Frame ☐	
		Patient's Frame ☐	
		NAME OF FRAME/MANUFACTURER	

Please send fully completed and **signed** NBN copy to:

Northwest Benefit Network
2323 Eastlake Avenue East
Seattle, WA 98102
(206) 726-3278

Tax Rate %

Total $

Provider, please retain the Doctor Copy for your records.
Lab Copy should only be sent to an NBN Approved Lab.

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NBN COPY