Mailing Address:
P.O. Box 1250
Tuscaloosa, Alabama 35403

Southland BENEFIT SOLUTIONS

VISION CLAIM FORM

CLAIMS MUST BE RECEIVED IN OUR OFFICE WITHIN 365 DAYS FROM DATE OF SERVICE.

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) GROUP ☐ HEALTH PLAN (SSN or ID) OTHER ☐ (ID)			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other		7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐		CITY STATE
ZIP CODE TELEPHONE (Include area code)	Employed ☐ Full-Time Student ☐ Part Time Student ☐		ZIP CODE TELEPHONE (Including Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐			b. EMPLOYERS NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME			c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d
11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of benefits to the undersigned physician or supplier for services described below. SIGNED _____

VISION RX	Sph	Cyl	Axis	Add
OLD OD.				
OS.				

VISION RX	Sph	Cyl	Axis	Add
NEW OD.				
OS.				

PHYSICIAN OR SUPPLIER INFORMATION

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____
2. _____ 4. _____

	24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	I. ID QUAL.	J. RENDERING PROVIDER ID #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
		$	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # ( )
SIGNED_____ DATE _____	A. B.	A. B.