



**CLAIM FORM**  
**(FOR VISION SERVICES)**

<b>EMPLOYER NAME :</b>			
<b>EMPLOYEE NAME :</b>		<b>LIFETIME BENEFIT SOLUTIONS ID # OR SS #:</b> <i>(ID # can be found on your ID card)</i>	
LAST	FIRST	MI	
<b>PATIENT'S NAME (IF DIFFERENT FROM ABOVE) :</b>			<b>PATIENT'S DATE OF BIRTH</b>
LAST	FIRST	MI	
<b>ARE YOU OR ANY OF YOUR DEPENDENTS COVERED UNDER ANOTHER PLAN?</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No
			If "YES," please provide the name of the Plan.
<b>IF YES, NAME OF PLAN:</b>			
<b>REMIT PAYMENT TO:</b> <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> PROVIDER			

**MAKE SURE ALL ENCLOSED BILLS LIST**

- ❖ DATE(S) OF SERVICE
- ❖ ITEMIZED CHARGES ("BALANCE BILL" STATEMENTS CANNOT BE PROCESSED)
- ❖ DIAGNOSIS CODE
- ❖ NAME OF PROVIDER

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

**Please print and return this form with documentation to the address displayed on the back of your benefit ID card for processing.**

Doing business as LBS Administrators and Flexible Benefit Insurance Solutions in California. Doing business as LBS Administrators in New Hampshire.