## CLAIM FOR VISION ASSISTANCE

## **BELL**SOUTH

MAIL TO: SPECTERA

BELLSOUTH UNIT

2811 LORD BALTIMORE DRIVE BALTIMORE, MD 21244-2644

1-800-839-3242

## HOW TO FILE YOUR CLAIM

- 1. YOU COMPLETE PART A
- 2. HAVE YOUR PHYSICIAN OR OPTOMETRIST COMPLETE PART B
- 3. HAVE THE SUPPLIER COMPLETE PART C
- 4. SEND THE COMPLETED FORM TO SPECTERA

PART A	PATIENT & INSURED INFORMATION		Retirees, Sponsored, and Class II Dependents are not eligible for Vision Care Benefits.
1. PATIENT'S NAME (First, Middle Initial, Last)	2. PATIENT'S BIRTHDAY (MO, DAY, YR)		3. EMPLOYEE'S NAME (First, Middle, Last)
	4. IF PATIENT CHILD OVER 19. ARE THEY A FULL TIME STUDENT?  ☐ YES ☐ NO		OFFICE PHONE #
5. EMPLOYEES ADDRESS (Street, City/State, Zip)	6. PATIENT'S SEX		7. EMP. SSN:
	☐ MALE ☐ FEMALE		-
	8. PATIENT'S RELATIONSHIP TO INSURED		9. EMPLOYEES (COMPANY)
	Self Spous	e Child Other	GROUP NO BST-V-ASO
10. OTHER VISION CARE COVERAGE	11. WAS CONDITION RELATED TO A. AN ACCIDENT		12. ARE ANY VISION SERVICES PROVIDED BY
Enter Name of Policy holder, Plan Name, Address, Policy or Medical Assistance number.	☐ YES ☐ NO		A HEALTH MAINTENANCE ORGANIZATION?
	B. AN AUTO A ☐ YES	ACCIDENT NO	YES NO LIST SERVICE
13. Does your wife/husband work?  YES NO If YES, what is their Employer's Name?			14. Is Patient Mentally Handicapped?  ☐ YES ☐ NO
If TES, what is their Employer's Name?			15. Is Patient Single? TYES NO
16. IS THIS CLAIM RELATED TO VIDEO DISPLAY TERMINAL BENEFITS? YES NO			
17. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES. I HEARBY CERTIFY TO THE ABOVE STATEMENTS AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.			
EMPLOYEE'S SIGNATURE DATE			
PART B EXAMINING PHYSICIAN OR OPTOMETRIST'S INFORMATION			
1. Date of this examination Date of last examination REFERRED BY AN OPTOMETRIST YES NO			
2. Are any of these charges covered by any other insurance, governmental or workers compensation law?			
If YES, please give the name of other insurance company and name of group			
3. Charge for this examination \$			
I hearby certify that the above statements accurately describe the services rendered and that I am			
Print or type Physician's name	Date	Signature of Physician	
(Address)  MUST BE FURNISHED UNDER Individual Practitioner's SSN			CR AUTHORITY OF LAW
		All others – Employer ID NO	
PART C		'S STATEMENT	
The following Lenses and/or Frames were ordered on for the above patient as prescribed on by myself or by Dr			Physician's Tax I.D. No. and SSN (required by Law) for Tax Reporting Purposes.
MATERIALS SUPPLIED □ Plastic □ Glass Extra Charge for Photosensitive or			e or EIN:
Type of Lens No of Lens	Charge	Anti-reflective, or other extras	e or
Single Vision Bifocal	\$	\$	SSN:
Trifocal			
Lenticular   Oversize			
Sunglasses			
Tint No Contact □ Soft □ Hard □ Disposable			
Other (Frames)			
Name of Supplier			
Address: City	Sta	te Zip Code	
Signature			Date