ACTiVA Benefits

Please submit to:

Activa Benefit Services, LLC.

P.O.BOX 37
Farmington, MI 48332
Claims: (877) 827-1414 or (616) 588-5340
Fax: (616) 588-7915

Vision Claim

Patient & Employee Information

1. Patient Name	2. Patient Date of Birth	3. Employee Name
4. Employee's Address	5. Patient's Sex ☐ Male ☐ Female	6. Employee Social Security Number
	7. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	8. Employee's Company Name
9. Other Vision Insurance Coverage – Enter Name and Policy Number.	10. Condition Related to: ☐ Patient's employment ☐ Auto Accident: If yes, please provide explanation.	

11. Patient's or Authorized Person's Signature. I Authorize the Release of any Vision Information Necessary to Process this claim. Signed Date	12. I Authorize Payment of Vision Plan Benefits to Undersigned Provider for Services Described below. Signed Date

☐ Pay Me (Sign Box 11 Only) ☐ Pay Provider (Sign Box 11 & 12)

Provider Information

Charges

Exam: Date of Service ____________________ $________________

Lenses: Date of Service ______________________ $________________

Type of Lens:

- ☐ Single ☐ Tinted
- ☐ Bifocal ☐ Sunglasses
- ☐ Trifocal ☐ Safety Glasses
- ☐ Other ______________________

Frames: Date of Service____________________ $________________

Contacts: Date of Service____________________ $________________

Please state reason for contacts (severe corneal astigmatism, severe corneal scarring, aphakia, or patient prefers contacts, etc.)

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Total $________________

Paid $________________

Balance Due $________________

Date	Provider Name	Signature	License #	SSN or Tax ID

Street Address	City	State	Zip Code	Telephone