Vision Claim Form

PO Box 91110
Sioux Falls, SD 57109
(800) 752-5863
Fax: (605) 328-6812
sanfordhealthplan.com

SANFORD HEALTH PLAN

You must attach original receipts that include an itemized breakdown of service/supply received.
Submission of this claim form does not guarantee payment of services. Claims may be delayed for missing information.
Mail completed forms to address above.

Subscriber and Patient Information

Subscriber Name:	Patient Name (*if different than subscriber*):	
Subscriber ID #:	Patient Date of Birth:	Patient Gender: Male Female
Address:	Patient's Relationship to Subscriber: Self Spouse Dependent Other_____	
City:	State:	Zip Code:
Phone:	Subscriber's Employer:	

Claim Information

Date of Service:	Provider Name:
Tax ID:	NPI:
Are services for a work related injury? Yes No	Are services for a non-work related injury? Yes No

If 'Yes' to either of above, please explain:

Services received for GLASSES

- ☐ Eye/Vision exam Paid: $_____
- ☐ Frames Paid: $_____

LENS TYPE (Check only one):

- ☐ Single-vision lenses Paid: $_____
- ☐ Bi-focal lenses Paid: $_____
- ☐ Tri-focal lenses Paid: $_____
- ☐ Lenticular lenses Paid: $_____

Services received for CONTACTS

- ☐ Eye/Vision exam Paid: $_____
- ☐ Contact lens fitting Paid: $_____
- ☐ Contact lenses Paid: $_____

You must attach original, itemized receipts for service/supply received. Your claim will not be processed without receipts.

Signature

FRAUD WARNING: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and be subject to civil penalties.

I authorize the release of any medical or other information necessary to process this claim.

Date:

Patient or Authorized Person's Signature (required for processing)