VISION CLAIM FORM

Submit completed form to:
Significa Benefit Services, **LLC**.
P.O. Box 7777, Lancaster, PA 17604-7777
Fax: 717-581-8379

For secure submission of claims
with PHI, go to:
www.significabenefits.com
select "Submit Secure Email or Attachment"

COMPLETE FOR ALL CLAIMS – Please print

Employer Name:_____ Employee Name:_____
Home Address:_____
Group#:_____ Member ID#:_____ Daytime Phone #:_____

Patient Information

Claim is for: ☐ You (Employee) If checked, go to next section ☐ Dependent If checked, complete below
Name:_____ Relationship: ☐ Spouse ☐ Child Birthdate:_____
Month / Day / Year

Authorization to Pay Benefits

☐ Pay doctor directly. If checked, you authorize payment to go directly to the doctor.
☐ You have paid the bill.

Other Medical Benefits/Health Insurance

Are you, your spouse or dependents covered for vision benefits through any other employer, welfare plan, Medicaid or Medicare? ☐ Yes ☐ No
If "Yes", complete the following and attach the itemized bill along with a copy of the Explanation of Benefits (EOB). If an EOB from the other plan is not available, please provide the name and address of the company providing benefits:

Name of person covered:_____ Social Security Number:_____
Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Surviving spouse ☐ Other (Please specify)_____
Is spouse or dependent also employed? ☐ Yes ☐ No. If "Yes", Health Benefit Company Name & Contact #:
_____

Employee Certification (must be signed by dependent (if not a minor) if this is their claim.

Notice: Any person who knowingly and with intent to defraud any insurance company or plan, files a statement of claim containing any materially false information or conceals information for the purpose of misleading, *commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

Employee Signature:_____ Date:_____
Dependent Signature (if needed):_____