Eyewear and Routine Vision Care Reimbursement Form National Account Groups

Horizon Blue Cross Blue Shield of New Jersey
Attention: Donna Rayca
250 Century Parkway, MT-04J
Mt Laurel, NJ 08054-1121

Important Information

1) Use a separate form for each family member.
2) Attach legible, itemized bills supporting each charge.
3) The following information is required on the itemized bill for the **eye examination:**
   a) Procedure code.
   b) Diagnosis and/or preventive code.
   c) Federal Tax Identification Number for the health care professional that performed the eye examination.

INSURED'S INFORMATION

Subscriber's Name: ______________________________________

Subscriber's ID Number: _______________________

Subscriber's Address: ____

City: ____ State: ____________ Zip: ____________________

Subscriber's Phone Number: ____________________________

Group Number: _________________________

Patient's Name: _______________________________________ Patient's Date of Birth: ____________________

Patient's Address (If Different from Subscriber): ____

City: ____ State: ____________ Zip: ____________________

Patient's Phone Number: _______________________________ Relationship to Subscriber: _________________________

EYE EXAM

Provider Name:____ Date of Service______________ Amount $____________

Address:____

City: ____ State: ____________ Zip: _____________________

Federal Tax Identification Number: _______________________________ Phone Number: _________________________________

Attach the itemized bill from the health care professional that performed the examination. The itemized bill must contain the procedure code, diagnosis code and Federal Tax Identification Number. **Bills missing any of this information will be returned to you.**

HARDWARE SERVICE	DATE OF SERVICE	AMOUNT
1. Hardware (glasses, lenses and/or contacts)	(/ /)	$
2. Hardware After Cataract Surgery	(/ /)	$
	Total	**$**

MEMBER/EMPLOYEE CERTIFICATION

I certify that the information provided on this Reimbursement Form is correct and complete, and that I am claiming benefits only for the charges actually incurred by the patient named.

______________________________ Date

____ Subscriber's Signature

FRAUD WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Fax the completed Reimbursement Form, along with the itemized bills to: **1-973-274-4414**
Or mail the completed Reimbursement Form along with the itemized receipt to:

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