VISION CLAIM FORM

(605) 328-6800 • 1-800-752-5863
Fax: (605) 328-6840
sanfordhealthplan.com

Claims may be delayed if information is missing. Please print legibly and provide complete information. Attach the original itemized receipts which include a breakdown of the services and/or materials you received. Submission of this claim form does not guarantee payment for services. Sign and date the claim form and mail to: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.

EMPLOYEE INFORMATION

Employee Name: ______________________________ Employee ID Number or SSN: ______________

Employee Address, City, State, Zip: ____

PATIENT/MEMBER INFORMATION

Patient Name: ______________________ Birthdate: ____/____/_____ Patient ID Number: ______________

Are services for a work related injury? ☐Yes ☐No Are services for a non-work related accident? ☐Yes ☐No

If yes to either of above, please supply details: ____

CLAIM INFORMATION

Date of Service: ______________ Provider Name: ______________________________

Provider Address, City, State, Zip: ____

Provider Phone: __________________ Tax ID: __________________ NPI: ________________

Frame: ______________________________ Amount: $______________

Lens Type: ______________________________ Amount: $______________

Coating: ______________________________ Amount: $______________

Coating: ______________________________ Amount: $______________

Miscellaneous: ______________________________ Amount: $______________

Total Charges: $________________

TOTAL Amount Paid: $________________

SIGNATURE

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

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim.

Employee Signature: ______________________________________Date:________________