

Cole Vision Services, Inc. Vision Claim Form

Mail completed claim forms to:

Cole Vision Services, Inc.
P. O. Box 8504
Mason, OH 45040-7111

Patient Information (REQUIRED)

Last Name		First Name		M. I.	Identification Number or SSN	
Street Address			City		State	Postal Code Telephone
Birth Date	Sex M____ F____	Relationship to the Subscriber: Self____ Spouse____ Child____ Other____			Patient Status Employed____ Full time student____	
Is Patient's Condition Related to: Employment____ Auto Accident____ Other Accident____				Is there Another Health Benefit Plan Yes____ No____ If yes, complete other insurance information.		

Subscriber Information (REQUIRED)

Last Name		First Name		M. I.	Identification Number or SSN	
Street Address			City		State	Postal Code Telephone ()
Birth Date	Sex M____ F____	Employer's Name		Insurance Plan Name		Subscriber's Group Number

Other Insurance Information

Other Insured's Last Name		First Name		M. I.	Other Insured's Policy or Group Number	
Birth Date	Sex M____ F____	Employer Name			Insurance Plan Name	

Provider Information (REQUIRED)

Provider Name				Telephone ()	
Street Address			City		State Postal Code

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. By signing below, I acknowledge that I have read the applicable Fraud Warning Statements on the back of this form.

Signed _____ Date _____

Claim Instructions

IMPORTANT: This claim form is intended for subscribers and their dependents that receive services from non-participating providers of Cole Vision Services, Inc. Please note that if your plan permits a non-participating provider to accept assignment, the provider must submit a completed CMS-1500 form (also known as a HCFA-1500 form) to Cole Vision Services, Inc. at the address below. If you receive services from a participating provider, no claim form is necessary. Read the following instructions carefully as incorrect, incomplete or illegible claims may result in claim payment being delayed or denied.

1. Enter all requested information in the Patient Information and Subscriber Information sections. Claims may be delayed if information is missing.
2. If you have other insurance, enter all information in the Other Insurance Information section.
3. Enter the Name, Address and Telephone number of the provider of services in the Provider Information Section.
4. Attach the original itemized receipts of the services and / or materials you received.
5. Sign and Date the claim form.

Submission of this claim form does not guarantee payment for services.

Mail the completed claim form to:

Cole Vision Services, Inc.
P.O. Box 8504
Mason, OH 45040-7111

If you are a subscriber or a dependent of a subscriber and you have any questions, please call 1-800-638-0166.

If you are a provider and have any questions, please call 1-800-655-1558.

FRAUD WARNING STATEMENTS

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or a fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: A person who knowingly and with intent to defraud, or deceive an insurance company files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

New Jersey: Any Person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, makes a claim for the proceeds on an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.