Mail Claim Form To:

MEDICAL MUTUAL OF OHIO®
Your healthcare partner since 1934

Medical Mutual of Ohio®
P.O. Box 6018
Cleveland, Ohio 44101-1018

VISION CLAIM FORM

PART I PATIENT AND CERTIFICATE HOLDER INFORMATION *(please print or type)*

1. Certificate Holder's name ______
   Address ______
   City ______
   State ______ Zip ______
   Phone (____) ______
2. Patient (first name, middle initial, last name)
3. Certificate Holder's ID number: ______
   Medical Mutual of Ohio® Plan code: ______
   (Numbers can be found on Certificate Holder's ID card.)
4. Group name: ______
5. Group number: ______

6. Patient's date of birth / / Age

7. Patient's relation to Certificate Holder
   - self (male) 1 ☐ self (female) 2 ☐ husband 3 ☐
   - wife 1 ☐ son 2 ☐ daughter 3 ☐
   - other male dependent 7 ☐ other female dependent 8 ☐
8. Is patient full-time student 19 years of age or older? ☐ yes ☐ no
   Name of school:
9. Was condition related to:
   A. Employment ☐ yes ☐ no
   B. Accident ☐ yes ☐ no
   Date of Onset: ______

10. ** **IMPORTANT** **
If the patient is covered by any other group or non-group health insurance, including Medical Mutual of Ohio®, please complete this section.
Name of other employer ______
Address of other employer ______
Name of other person employed ______
Birthdate of other person employed ______
Relationship to patient ______
Other health care plan ______
If the patient is a child and parent's are divorced, please answer the following:
a. Which parent has custody of the patient? ______
b. Is there a court decree that states which parent is responsible for medical bills?
______ yes ______ no. If yes, please attach a copy of the court decree.

11. Is the patient eligible for Medicare? ☐ yes ☐ no

12. Describe the illness, injury or symptom: ______
Date symptom first appeared: ______

5a. I authorize release of any information relative to this claim to be used by Medical Mutual of Ohio® or a review agency with which it has contracted solely for the purposes of determining reimbursement.

______ Date ______
(Signature of Certification Holder or Spouse)

PART II PHYSICIAN OR PROVIDER INFORMATION *(to be completed by physician or provider only)*

OFFICE SERVICES

Date of examination ____/____/____

Service Description	FEES
TOTAL OFFICE FEES	

Refraction ☐ yes ☐ no

OPTICAL STYLE

☐ Glass ☐ Plastic ☐ Other
☐ One eye ☐ Both eyes

CONTACT LENSES

☐ Due to cataract surgery ☐ Other
☐ To obtain 20/70 vision

OPTICAL CHARGES (Date of service ____/____/____)

Lens	Acquisition fee (L)	Acquisition fee (R)	Dispensing fee (L)	Dispensing fee (R)
Single vision				
Bifocal				
Trifocal				
Lenticular				
Tint				
Type______				
Photochromatic				
Contact lenses				
Frames				
Options				
SUBTOTAL:				
TAX:				
OPTICAL CHARGES TOTAL:				

I certify that the services were performed by me or in my presence under my supervision

Physician/provider name ______
Address ______
City ______ State ______ Zip ______
Provider Tax ID ______
▶ Signature ______

MED/SURG 006 R5/88

X5329 R1/06

FOR THE CERTIFICATE HOLDER

1. Use this form for all your vision claims. Use a separate form for each patient and each physician.
2. Complete all items on Part I of the form for both the patient and the Certificate Holder. If any information is missing a delay in processing will result. Make sure you sign the form in Block #5A to authorize release of information.
3. After completion of Part I give the form to your physician or provider.

FOR THE PHYSICIAN OR PROVIDER

1. Use a separate claim form for each patient and each provider rendering service.
2. Review the top of the form to make sure the employee has provided all information, especially Coordination of Benefits (Block 10) and a signature (Block 5A). Missing information will cause a delay in processing.
3. Complete Part II with all information pertinent to the patient's treatment.
4. Be sure to use your taxpayer ID number.

WARNING: 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. (Ohio Revised Code Section 3999.21)