

**VISION CLAIM FORM**



**Regence**

1800 Ninth Avenue  
 P.O. Box 21065  
 Seattle, WA 98111-9145  
 http://www.wa.regence.com/boeing

Regence BlueShield is an Independent Licen  
 of the Blue Cross and Blue Shield Associatio

1. EMPLOYEE / RETIREE INFORMATION		2. PATIENT INFORMATION	
Name (First, Middle, Last)		Name (First, Middle, Last)	
Address		Address (If different)	
City State Zip		City	State Zip
Home Telephone Number ( )		Boeing Telephone Number ( )	Date of Birth (Month/Day/Year) / /
Alpha Prefix and Member ID (see Member card)		Date of Birth (Month/Day/Year) / /	Do you have other group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following
		Group Number	Employee/Retiree Name
		Insurance Company Name and Address	

3. EXAMINING PHYSICIAN OR OPTOMETRIST INFORMATION			
Date of Service / /	Services Rendered	Refraction Included? <input type="checkbox"/> Yes <input type="checkbox"/> No	Charge
Physician's or Optometrist's Name, Address & Zip Code		Diagnosis	
		<input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist Enter the Taxpayer Identifying Number to be used for 1099 reporting purposes. You are required under authority of law to furnish your Taxpayer Identifying Number.	
Signature of Physician or Optometrist		Date Signed	

**4. SUPPLIER INFORMATION (To be completed by dispenser of prescription)**

**All sections must be fully completed before this claim will be processed.**

Lenses for <input type="checkbox"/> One Eye <input type="checkbox"/> Both Eyes	Date Ordered	Date Delivered
Glasses <input type="checkbox"/> One Pair <input type="checkbox"/> Two Pair	Special Features Yes No (Extra Charge, if any)	Frames
<input type="checkbox"/> Single Vision \$ _____	Plastic Lenses <input type="checkbox"/> <input type="checkbox"/> \$ _____	<input type="checkbox"/> Existing \$ _____
<input type="checkbox"/> Bifocal \$ _____	Oversize <input type="checkbox"/> <input type="checkbox"/> \$ _____	<input type="checkbox"/> New \$ _____
<input type="checkbox"/> Trifocal \$ _____	Tinting (of any kind) <input type="checkbox"/> <input type="checkbox"/> \$ _____	<input type="checkbox"/> If new, why? _____
<input type="checkbox"/> Lenticular \$ _____	Blended focal <input type="checkbox"/> <input type="checkbox"/> \$ _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____ \$ _____	Other _____ <input type="checkbox"/> <input type="checkbox"/> \$ _____	<input type="checkbox"/> _____
Aphakic? <input type="checkbox"/> Yes <input type="checkbox"/> No	TOTAL CHARGES (Including tax): \$ _____	

Contacts: Therapeutic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Aphakic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Daily Wear Spherical Lenses	Daily Wear Toric	Flexible Wear
<input type="checkbox"/> Hard \$ _____	<input type="checkbox"/> Soft \$ _____	<input type="checkbox"/> Soft \$ _____
<input type="checkbox"/> Soft \$ _____	<input type="checkbox"/> Gas Permeable \$ _____	<input type="checkbox"/> Gas Permeable \$ _____
<input type="checkbox"/> Gas Permeable \$ _____		
<input type="checkbox"/> Other _____ \$ _____		
Supplier's Name, Address & Zip Code	Physician/Supplier employer ID No.	Enter the Taxpayer Identifying Number to be used for 1099 reporting purposes. You are required under authority of law to furnish your Taxpayer Identifying Number.
	Telephone Number	
Signature of Physician or Optometrist	Date Signed	

**5. EMPLOYEE / RETIREE RELEASE INFORMATION**

**Employee/Retiree/Patient/Authorized Person's signature (read before signing). I authorize the release of any medical information necessary to process this claim from my provider of service or any insurance company involved in final benefit determination.**

If allowed by the participating Blue Cross or Blue Shield Plan, I direct payment to be made to:  The provider of service  The employee/retiree

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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

# INSTRUCTIONS

**A.** Most providers will bill directly for you and no claim form will be necessary. However, if you do incur expenses from a provider who will not bill the plan directly, you will need to complete sections 1, 2, and 5 of the claim form and then see **B** for instruction on sections 3 and 4.

**B.** Have your provider complete sections 3 and 4 (Physician or Supplier information) or attach completely itemized bills.

An itemized bill is one that includes:

- Patient's name
- Member ID
- Alpha Prefix
- Date of service
- Type of services rendered
- Nature of the condition being treated
- Physician's or supplier's taxpayer identification number

If this information is missing, please write it in the appropriate area(s).

**C.** If services were rendered in **Western Washington**, please submit completed claim forms to:

**Regence BlueShield**  
**PO Box 21065**  
**Seattle, WA 98111-3065**

**D.** If services were rendered **outside of Western Washington**, please submit the claim form to the Blue Cross or Blue Shield plan in the area where services were rendered. If you need help locating the address of that plan, or questions about the claim form, please contact Regence BlueShield at 1 (800) 422-7713.

The diagram shows a Regence BlueShield member card. Arrows point from labels to specific fields on the card:

- Alpha Prefix:** Points to the 'Z' in the ID number 'ZLB123456789'.
- Member ID:** Points to the 'LB123456789' portion of the ID number.
- Group Number:** Points to the '055137' in the 'Group No.' field.

The card itself contains the following information:

Regence BlueShield  
An Independent Licensee of the Blue Cross and Blue Shield Association  
Boeing Selections<sup>SM</sup>

ID No. ZLB123456789      Group THE BOEING COMPANY  
Group No. 055137      Plan/Branch 932 00

Subscriber/Dependent	M	V	RX
00 JOHN Q CUSTOMER	Y	Y	Y
01 JANE T CUSTOMER	Y	Y	Y
02 SUSIE Q CUSTOMER	Y	Y	Y
03 BILLY B CUSTOMER	Y	Y	Y
04 TIMMY A CUSTOMER	Y	Y	Y

Medical Copay    OC 5    ER 50

The card pictured above may not match your particular member card. This map is meant to be a guide to help you identify your alpha prefix, member and group numbers.