

VISION CLAIM TRANSMITTAL



Claim Address:
UnitedHealthcare
PO Box 740800
Atlanta, GA 30374-0800

Employer Name: North Jersey Health Insurance Fund
Group (Policy) Number: 705996

Vision Care Providers – please make sure you have indicated the patient’s diagnosis, date of service, and circled the appropriate procedure codes in Section E prior to submitting this claim.

A. MEMBER/EMPLOYEE INFORMATION (Please include your member ID on all documentation):

Member # (SSN)	Last Name:	First Name:	MI:
Home Address	City	State	Zip Code:

B. PATIENT INFORMATION:

Last Name:	First Name:	MI:	Date of Birth:
Sex M <input type="checkbox"/> F <input type="checkbox"/>	Relationship to Member:	Full Time Student Yes <input type="checkbox"/> No <input type="checkbox"/>	School Name:

C. ACCIDENT INFORMATION:

Work Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Accident Occurred: / /
How did the accident occur:		

D. OTHER INSURANCE

Is the patient covered by another insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please complete the following:
Name of person Carrying other insurance:	Date of Birth: / /
SSN #:	Name of the Other Insurance Carrier
Policy Number:	Employer Name:

E. THIS SECTION TO BE COMPLETED BY PROVIDER

PLEASE CHECK APPROPRIATE BOXES AND INDICATE APPLICABLE CHARGES:

E x a m s	Diagnosis: V720	Date of Purchase: _____	
	Date of Exam: _____	L	Single Vision V2101 \$ _____
	New Patient 92002 \$ _____	e	Bifocals V2200 \$ _____
	92004 \$ _____	n	Trifocals V2300 \$ _____
	Established Patient 92012 \$ _____	s	Lenticular V2121 \$ _____
92014 \$ _____	e		
Refraction 92015 \$ _____	s		
92310 \$ _____			

F r a m e s	Date of Purchase: _____	Date of Purchase: _____	
	Standard V2020 \$ _____	C	PMMA V2500 \$ _____
	Deluxe V2025 \$ _____	O	Gas Permeable V2510 \$ _____
		L	Hydrophilic V2520 \$ _____
		n	Scleral V2530 \$ _____
	e		
	s		

Description:			
Total Charges \$ _____	Amount Paid by the Employee \$ _____		
Name of Provider who Performed the Services:		Phone (Area Code):	
Address:		City-State-Zip Code:	
Provider’s Signature:	Tax ID No.:	Must be Furnished	
Date:	Degree/Title:	Employee ID No.:	Under Authority of Law

F. ASSIGNMENT OF BENEFITS

Please sign below <u>only if you want UnitedHealthcare to pay benefits directly to the provider of vision service:</u>		
Patient Signature:	Member Signature:	Date:

NOTE: Please do not attach any receipts or bills to this form. Make sure form is completely filled out and mail only this form to the above address.