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 ☐ F ☐	Relationship to Member:	Full Time Student Yes ☐ No ☐	School Name:

C. ACCIDENT INFORMATION:

Work Accident? Yes ☐ No ☐	Auto Accident? Yes ☐ No ☐	Date Accident Occurred: / /
How did the accident occur:		

D. OTHER INSURANCE

Is the patient covered by another insurance plan? Yes ☐ No ☐ 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:

Exams

Diagnosis: V720

Date of Exam: ____ _____

New Patient	92002	$_____
	92004	$_____
Established Patient	92012	$_____
	92014	$_____
Refraction	92015	$_____
	92310	$_____ _

Lenses

Date of Purchase:_____

Single Vision	V2101	$_____
Bifocals	V2200	$_____
Trifocals	V2300	$_____
Lenticular	V2121	$_____

Frames

Date of Purchase: _____

Standard	V2020	$_____
Deluxe	V2025	$_____

Contact Lenses

Date of Purchase:_____

PMMA	V2500	$_____
Gas Permeable	V2510	$_____
Hydrophilic	V2520	$_____
Scleral	V2530	$_____ _

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 only if you want UnitedHealthcare to pay benefits directly to the provider of vision service:		
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.