Nippon Life Benefits®

Print

Vision Care Claim

Please mail completed form to:
Nippon Life Insurance Company of America
Attn: Claim Center
P.O. Box 25951
Shawnee Mission, KS 66225-5951

See Page 2 for Claim Filing Instructions.

Part A - Patient & Employee Information

1. Patient name

2. Relationship to employee ☐ self ☐ wife ☐ husband ☐ daughter ☐ son ☐ stepchild ☐ foster child

3. Sex ☐ M ☐ F

4. Patient birth date (mo/day/year)

5. If full-time student School City

6. Employee name (first/middle/last)

7. Employee's social security number

8. **Plan and ID numbers (printed on employee's ID card)** Plan I.D.

9. Employee/mailing address

Is this a new address? ☐ yes ☐ no

City State ZIP

10. Employer (company) name and address

City State ZIP

11. Is employee ☐ single ☐ married ☐ divorced ☐ widowed

12. Spouse's name and birth date (mo/day/year)

13. Spouse's social security number

14. Is spouse employed? ☐ yes ☐ no

15. If "yes," give name, address, and telephone number of spouse's employer

16. Is patient covered for vision care by another plan? ☐ yes ☐ no

If "yes," give name of person carrying the other coverage.

Insurance Company or plan name Group number

Name and address of carrier

17. Was condition related to:
A. Patient's employment ☐ yes ☐ no B. An auto accident ☐ yes ☐ no

New York Fraud: 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 false material thereto, commits a fraudulent insurance act, which is a crime, and shall also be a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

18. I authorize the release of any information necessary to process this claim.

Signed (patient or parent if minor) ▶

Date

Part B – Examining Physician or Optometrist's Information

Indicate diagnosis, nature of disease, injury or vision disorder

If contact lenses, would the visual acuity be corrected to 20/70 in the better eye by use of conventional lenses? ☐ yes ☐ no

Report of services or attach itemized bill. (If previous form submitted to this carrier, you need to show only dates and services since last report.)

Date of service	Services rendered	Charges
		$
		$

Physician's or optometrist's name Phone number Total charges $

▶ Physician's or optometrist's address (street, city, state, ZIP code) Federal I.D. number or Tax I.D. number Amount paid $

▶ Physician's or optometrist's signature Date Your patient's group number Balance due $

Authorization to pay - Sign only if you want benefits paid directly to physician or optometrist.

I authorize payment of vision care benefits to the physician or optometrist described in Part B.

Date

▶ Employee or authorized person's signature

Part C – Supplier Information (To Be Completed by Dispenser of Prescription other than Prescribing Physician)

Type	Date of purchase	Date of delivery to patient	Charges
Lenses			
Frames			
Contacts			
Tint			
Coating			
Oversizing			
Other			

Supplier name and address (street, city, state, ZIP code)

Supplier phone number

Federal I.D. number or Tax I.D. number

Type of lenses:
☐ single vision ☐ bifocal ☐ trifocal ☐ lenticular
☐ contact lenses ☐ disposable contact lenses
number of months supplied: _____

Total charges $

▶ Signature of supplier | Date

Patient's group number | Amount paid $ | Balance due $

Authorization to pay – Sign only if you want benefits paid directly to supplier.

I authorize payment of vision care benefits to the supplier for services described in Part C.

▶ Employee or authorized person's signature | Date

☐ **Payment receipt or cash register receipt for prescription attached (See item 5 below.)**

Instructions to Employee

(1) Complete questions 1 through 18 (**Part A**) on Page 1 and sign and date line 18.

(2) Have patient's physician or optometrist complete the **Examining Physician or Optometrist's Information** section (**Part B**) on Page 1.

(3) Have patient's supplier (if other than examining physician or optometrist) complete the **Supplier Information** section (**Part C**) on Page 2.

(4) Attach itemized bills for expenses not shown on Page 1. If you want benefits paid directly to the physician or optometrist, sign the **Authorization to pay** in section (**Part B**) on Page 1. If you want benefits paid directly to the supplier (if other than examining physician or optometrist), sign the **Authorization to pay** in section (**Part C**) on Page 2.

(5) Attach payment receipt or cash register receipt to claim form if prescription is being filled by someone other than the examining physician or optometrist.

Notice Requirements

Applicable to all states not listed elsewhere on this form: Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form 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. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

INDIANA FRAUD

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

KENTUCKY FRAUD

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NEW JERSEY FRAUD

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

OHIO FRAUD

Any person who, with intent to defraud or knowing that he or she 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.

TENNESSEE FRAUD

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

TEXAS FRAUD

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.