SINGLE
VISION
SOLUTION

VISION CARE PROGRAM

INSTRUCTIONS FOR SUBMITTING THE ATTACHED APPLICATION FOR BENEFITS

Please read carefully before completing this form.

GENERAL INFORMATION

- Separate all itemized billings or paid receipts according to each eligible family member
- Fill out a separate claim form for each eligible family member
- Attach each member's paid itemized receipts to the completed form

EACH ITEMIZED BILLING OR PAID RECEIPT MUST CONTAIN:

- Name and address of provider (Doctor or person providing the vision care)
- Patient's full name
- Exact date (Month, Day, Year) each service was performed
- Type of service performed (Procedure)
- Amount charged for each individual service performed
- Attach explanation of benefits when billing more than one insurance (example: Blue Cross/Blue Shield, Medicare)

Cash register receipts, cancelled checks, credit card receipts, money order receipts, and personal itemizations are not acceptable.

Make any needed copies of itemized billings or paid receipts for your files before submitting the originals. All materials submitted will be retained for our files.

Please complete the top portion of the claim form following the instructions on the next page. Please type or print clearly.

After completing the claim form, detach the instruction sheet from the claim form along the perforated line. Keep the copy for your records. Attach all itemized paid receipts and other information requested above to the claim form and mail to:

Single Vision Solution
Vision Care Program
P.O. Box 464
Mt. Clemens, MI 48046-0464

Questions? Telephone: 1-800-225-3095

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR VISION CARE BENEFITS

BOXES 1 THRU 19 TO BE COMPLETED BY EMPLOYEE

Boxes 1-3 — Fill in employee's last name, first name and middle initial.

Boxes 4-7 — Fill in employee's street address, city, state and ZIP code.

Boxes 8 — Fill in employee's 9-digit Social Security Number.

Boxes 9-11 — Fill in patient's last name, first name and middle initial.

Boxes 12 — Indicate sex of patient.

Boxes 13 — Fill in patient's date of birth (Month/Day/Year.)

Boxes 14 — Indicate patient's relationship to employee.

Boxes 15 — Indicate whether patient has coverage by another group medical plan provided by another employer, if yes, give carrier/plan name and policy number.

Boxes 16 — Indicate whether services performed were the result of patient's employment.

Boxes 17 — Indicate whether services performed were by SVS Vision Optical Centers (or an affiliated provider.)

Boxes 18 — Indicate any additional information that may help in review of your claim (emergency services, etc.)

Boxes 19 — The employee must sign the claim form. Please include the date, your area code and telephone number.

***Claim form will be returned if not signed.**

BOXES 20 THRU 29 TO BE COMPLETED BY PROVIDER

If the Doctor, person who provided the vision care services completes the claim for you, please advise him/her to use the procedure and explanation code structures on the back of the form. Please ask your provider to supply their license number and speciality in the spaces provided at the bottom of the claim form.

SINGLE VISION SOLUTION

VISION CARE PROGRAM

APPLICATION FOR BENEFITS

(Please Print Clearly and Sign Below)

1. EMPLOYEE LAST NAME	2. EMPLOYEE FIRST NAME	3. MID INIT

4. EMPLOYEE STREET ADDRESS

5. CITY	6. STATE	7. ZIP CODE
		–

8. SOCIAL SECURITY NUMBER

PATIENT INFORMATION

9. PATIENT'S LAST NAME	10. PATIENT'S FIRST NAME	11. MID INIT	12. SEX	13. DATE OF BIRTH
			M ☐ F ☐	

14. RELATIONSHIP TO EMPLOYEE	15. OTHER INSURANCE CARRIER/PLAN? IF YES, INDICATE CARRIER AND ATTACH EOB
☐ SELF ☐ SPOUSE ☐ DEPENDENT	☐ YES ☐ NO

16. WERE SERVICES CONNECTED WITH PATIENT'S EMPLOYMENT?	17. WERE SERVICES PERFORMED BY A SVS/AFFILIATED PROVIDER?
☐ YES ☐ NO	☐ YES ☐ NO

18. ADDITIONAL INFORMATION

19. I certify that the above information is true and the attached material is correct and unaltered. I understand that all material submitted becomes the property of SINGLE VISION SOLUTION (SVS) and hereby authorize the release of any and all information regarding vision care services received under the SVS Vision Care Program to SVS or those designated by SVS.

EMPLOYEE SIGNATURE	DATE	AREA CODE	TELEPHONE NUMBER

SERVICE INFORMATION

20. SERVICE LINES	A. DATE OF SERVICE	B. PROCEDURE	C. TOTAL CHARGE	D. EMPLOYEE LIABILITY	E EXPL CODE	F DIAGNOSIS (ICD 10) CODE
1						
2						
3						
4						
5						

21. TOTAL SERVICE LINES		22. TOTAL CHARGES		

PROVIDER INFORMATION

23. LICENSE NUMBER	24. SP	25. PROVIDER NAME

26. PROVIDER ADDRESS	27. CITY

DOCUMENT NUMBER • DO NOT WRITE IN THIS AREA

28. STATE	29. ZIP CODE

PROVIDER IDENTIFICATION (OTHER THAN FORD MOTOR COMPANY)

I CERTIFY THE SERVICES HEREIN WERE PERFORMED BY ME OR UNDER MY DIRECTION AND PERSONAL SUPERVISION AND IN MY PRESENCE.

PROVIDER SIGNATURE	DATE

APPROVAL NUMBER

TO THE PROVIDER

When completing the front of this form for the patient, please use the following.

PROCEDURE: Use the code(s) that best describe services performed.

VISION EXAM
92002 New Patient, Intermediate
92004 New Patient, Comprehensive
92012 Established Patient, Intermediate
92014 Established Patient, Comprehensive
92015 Refraction

FRAMES
V2020 Standard Frame
V2025 Designer Frame

LENSES
V2100 Single Vision
V2200 Bifocal
V2300 Trifocal
V2781 Progressive

CONTACT LENSES
V2500 Contact Lenses
92310 Contact Lens Fitting

SPECIAL LENSES
V2715 Prism

SPECIAL COATINGS/EXTRAS
V2750 Anti Reflective coating
V2755 UV protection
V2760 Scratch resistant coating
V2760 Scratch resistant coating under 13
V2762 Polarization, any lens
V2784 Polycarbonate
V2744 Photochromic

TINTS
V2745 Tint

EXPLANATION CODE: Use the characters below to report a 2-digit code when an exam or contact lenses are provided. No other services will require an explanation code.

	FIRST DIGIT		SECOND DIGIT	
	DIGIT	DESCRIPTION	DIGIT	DESCRIPTION
EXAM	**1**	Vision Testing – Lenses Prescribed	**A**	Regular Exam
	2	Vision Testing – Lenses Not Prescribed	**B**	Subsequent Exam with Additional Testing (Referral Exam)
CONTACT LENSES	**3**	One Prescription Lens Change in Vision	**C**	To Correct Visual Acuity to at Least 20/70 in the Better Eye
	4	One Lens – No Change in Vision	**D**	Not to Correct Visual Acuity to at Least 20/70 in the Better Eye
	5	Two Lenses Change in Vision	**E**	Required for Keratoconus
	6	Two Lenses – No Change in Vision	**F**	Required for Irregular Astigmatism
			G	Required for Irregular Corneal Curvature

SPECIALTY CODE (BOX 24): Indicate one of the following 2-digit codes that identifies provider specialty.
1 – Ophthalmology (M.D.)
2 – Ophthalmology and Otorhinolaryngology (D.O.)
3 – Optometrist (O.D.)
4 – Medical Supplies (Supplier)
5 – Other