BlueCross BlueShield of Georgia

An Independent Licensee of the Blue Cross Blue Shield Association

ROUTINE VISION SERVICE REPORT

P.O. Box 9907
Columbus, Georgia 31908-6007

MEMBER I.D. CARD (INCLUDE ANY LETTERS)

MEMBER'S GROUP NO. OR GROUP NAME (INCLUDE ANY LETTERS)

PATIENT INFORMATION

PATIENT LAST NAME | FIRST

PATIENT STREET ADDRESS

CITY | STATE | ZIP CODE

HOME PHONE | PATIENT'S SEX (M / F) | PATIENT'S DATE OF BIRTH | PATIENT'S RELATIONSHIP TO MEMBER (SELF / SPOUSE / CHILD / OTHER)

DIAGNOSIS
V 720

ATTENTION!
Please keep all written information within the screened boxes to assure timely processing of this form.

Thank you!

OTHER GROUP HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER, PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER FOR VISION BENEFITS ONLY. IF NONE SO STATE.

POLICY NO.

PAYMENT TO PROVIDER | PAYMENT TO SUBSCRIBER

I authorize the release of any medical information necessary to process this claim and also certify that the above information is correct.

Authorized Person's Signature | Date

I authorize payment of benefits to undersigned provider for services described below.

Authorized Person's Signature

TO BE COMPLETED BY PROVIDER

DATE OF SERVICE	✓	PROCEDURE CODE	When "OTHER" is checked, fully describe services or supplies furnished	CHARGES
		V2020	Frames	
		V2199	Single Vision Lens	
		V2299	Bifocal Lens	
		V2317	Trifocal Lens	
		V2781	Progressive Lens	
		V2599	Contact Lens (List Type)	
			OTHER SERVICES	
		S0620	Routine ophthalmological examination including refraction; new patient	
		S0621	Routine ophthalmological examination including refraction; established patient	
		S0592	Comprehensive contact lens evaluation	

PRINT CLEARLY - BLACK INK ONLY

TOTAL CHARGES ➡

PROVIDER

TAX I.D. NO. | LICENSE NO. | YOUR PATIENT'S ACCOUNT NO.

LAST NAME | FIRST

PROVIDER STREET ADDRESS

CITY | STATE | ZIP CODE

PHONE

I CERTIFY THAT I PERSONALLY RENDERED THE SERVICES DESCRIBED ABOVE TO THIS MEMBER

AUTHORIZED SIGNATURE

PRINT CLEARLY - BLACK INK ONLY

H-AAP-001410-06/02

Vision Claim Filing Checklist

Before filing a vision claim the member should ensure that the following is completed for timely processing:

- ✓ Copy of superbill from a provider's office or sales receipt is attached to claim form
- ✓ Ensure that all documentation is legible and provider's tax identification number is present on a claim
- ✓ Ensure that provider signature is present on claim
- ✓ Ensure that the above documentation is attached to a Routine Vision Service Report