SAN JUAN COUNTY

VISION CLAIM FORM

1. Call for verification of benefits
2. Complete this Form
3. Attach all Bills
4. Mail to address shown

Tall Tree Administrators
Post Office Box 71747
Salt Lake City, Utah 84171
http://www.talltreehealth.com/

TO BE COMPLETED BY EMPLOYEE: All sections must be completed

Employee Name		Date of Birth
Mailing Address	City and State Zip	Phone Number
For Dependent Claim: Dependent Name	Relationship	Date of Birth

For all Claims:

Are you or your dependents entitled to visual care benefits under any other insurance plan? ___Yes ___ No
If yes, give the name and address of other insurance carrier:

Is claim being made for workmen's compensation? ___ Yes ___ No
Is treatment as a result of an accident? ___ Yes ___ No

TO BE COMPLETED BY DOCTOR, PROVIDER OF SERVICE, OR EMPLOYEE:

Date Service Began

Date Service Completed

Print or Type Doctor/Provider's Name

Degree

Doctor/Provider's Address

City, State, Zip

Telephone Number

Doctor/Provider's Signature

Individual Practitioner's SS# or TIN

Exam $

Frames $

Lenses - Single $

Lenses - Bifocal $

Lenses - Trifocal $

Lenses - Contacts $

Lenses Lenticular $

Tax $

Total Charges $

IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW	**IF PAYMENT IS TO BE MADE TO THE EMPLOYEE, SIGN BELOW**
AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment of benefits directly to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for any charges not covered by the authorization. X	AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT: I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or service. I hereby certify the information provided is correct and true to the best of my knowledge. X
Employee's Signature Date	Employee's Signature Date

OFFICIAL USE ONLY

Exam $_____ **Frames $**_____ **Lenses $**_____ **Total $**_____

Type: ☐S ☐B ☐T ☐C

Approved by:_____ **Date:** _____

SUMMARY OF VISION BENEFITS/FOR HR USE ONLY

All benefits described in this Summary are subject to all of the terms, provisions and conditions specified in the document.

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Eye Examination	**$100.00**	per Covered Person per Calendar Year.
Single Lenses	**$60.00**	per Covered Person per Calendar Year.
Bi-focal Lenses	**$75.00**	per Covered Person per Calendar Year.
Tri-focal Lenses	**$90.00**	per Covered Person per Calendar Year.
Lenticular Lenses	**$70.00**	per Covered Person per Calendar Year.
Contact Lenses	**$110.00**	per Covered Person per Calendar Year.
Frames	**$75.00**	per Covered Person every two (2) Calendar Years.
Lasik Surgery	**$500.00**	per Covered Person per Calendar Year.
Single Lens Replacement	The maximum amount for a single lens is 50% of the maximum amount payable for a pair of lenses	

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Medically Necessary Contacts **$150.00** If prescribed where visual acuity is not correctable to 20/70 in the better eye except by the use of contact lenses, or as a requirement following cataract surgery, or for treatment of keratoconus or anisometropia when contact lenses are customarily prescribed as part of the treatment.

No benefits are payable for eyeglasses and contact lenses in the same calendar year. Return claim form (s) and itemized statement (s) to the Human Resources Employee Benefits Department for processing.