Town of Hempstead
PART A – TO BE COMPLETED BY EMPLOYEE

HEALTHPLEX.
THE DENTAL BENEFIT EXPERTS™

STATEMENT OF VISION CARE EXAMINATION AND MATERIAL

1. Employee's Name (Last, First, Middle)
2. Employee's Social Security #
3. Employee's Location
4. Group Number **GG-076**

5. Patient's Name (Last, First, Middle)
6. Patient's Relationship to Employee: ☐ Self ☐ Child ☐ Spouse ☐ Other
7. Patient's Sex ☐ M ☐ F
8. Patient's Date of Birth

9. Employee's Address
10. Telephone Number
11. Employee's Status ☐ Active ☐ Retired ☐ Hourly ☐ Salaried

12. Employer's Name and Address

13. Is Patient Covered For Vision Care by Another Plan ? ☐ Yes ☐ No
Vision Plan Name
Group Number
Name and Address of Carrier

14. If Claim is due to accident, indicate date, time, place and how accident occurred
15. Did accident occur at work? ☐ Yes ☐ No

16. To all physicians and other health professionals, and all hospital and other health care institutions. You are authorized to provide Healthplex, Inc. and any independent claim administrators and consulting health professionals acting on Healthplex's behalf information concerning health care advice, treatment or supplies provided the patient. This information will be used for the purpose of evaluating and administering claims for benefits. Healthplex may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the Policy contract. This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Date:______________________ Patient's or Authorized Person's Signature ______________________

17. I hereby authorize payment directly to the doctor and/or dispenser of the vision care benefits otherwise payable to me.

Signed (Employee) ______________________ Date ______________________

PART B – TO BE COMPLETED BY DOCTOR

1. Please check one: ☐ Non-Participating ☐ Participating
2. Doctor's Name (Last, First, Middle)
3. Enter the taxpayer I.D. # to be used for 1099 reporting purposes and your NPI number.
TI Number ______________________
NPI Number ______________________

4. Doctor's Address
5. Phone No.
6. Title ☐ MD ☐ DO ☐ OD
7. Examination Date
8. Has cataract surgery been performed? ☐ YES ☐ NO
9. Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses? ☐ Yes ☐ No
10. Does patient require a prescription change at this time? ☐ YES ☐ NO
11. Diagnostic code(s) ________ ________ ________ ________ ________
12. Indicate diagnosis or nature of disease or injury or vision disorder, indicate procedure code #s.
13. Visual acuity corrected to

PROFESSIONAL SERVICES	AMOUNT
EXAMINATION CHARGE	
SALES TAX	
TOTAL	
AMOUNT PAID BY PATIENT	

14. DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
R.E.	.	.			
L.E.	.	.			
Reading Add	R.E.	+ .	L.E.	+ .	

15. I hereby certify that I have performed the services as indicated hereon.

Doctor's Signature Date

PART C – TO BE COMPLETED BY DISPENSER

In lieu of dispenser completing this section a laboratory bill can be attached. Dispenser must sign this form, enter amount paid by patient.

1. Please check one: ☐ Non-Participating ☐ Participating
2. Dispenser's Name
3. Enter the taxpayer I.D. # to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.
4. Dispenser's address
5. Phone No.
6. Dispenser's Title ☐ Ophthalmologist ☐ Optician ☐ Optometrist
8. Date Order Deliver
9. Type of lenses dispensed ☐ None ☐ 9511 Single ☐ 9512 Bifocal ☐ 9513 Trifocal [ ] 9531 Telescopic ☐ 9521 Contacts ☐ 9561 Sunglasses ☐ Other (Specify)__________
10. Contact lenses (If contact lenses, please complete) ☐ Therapeutic ☐ Non-Therapeutic ☐ Hard ☐ Soft
11. Frame, model or cat. # & Size
12. Frame Code 9541 ☐ 9562 ☐

Professional Services		Amount
Lens Charge		
Frame Charge		
OPTIONS: Opt	Lens	
	Frm	
Disp. Fee	Lens	
	Frm	
Sales Tax (if any)		
Total		
Amount Paid by Patient		

13. I hereby certify that I have performed the services as indicated hereon.

Dispenser's Signature Date

VISION CARE BENEFITS REQUEST FORM

HOW TO REQUEST BENEFITS

EMPLOYEE	COMPLETE THE "PATIENT INFORMATION" (PART A - ITEMS 1 THROUGH 17) ON THE REVERSE SIDE OF THIS FORM. If you wish your benefits paid directly to your Doctor or Optometrist, sign item 17. If you wish benefits paid directly to the provider of materials, sign item 17. A separate form should be submitted for each family member. Please be sure you have provided the employee's SOCIAL SECURITY. <u>SEND THE COMPLETED "BENEFIT REQUEST FORM" DIRECTLY TO THE HEALTHPLEX OFFICE.</u>
DOCTOR OR OPTOMETRIST	PLEASE COMPLETE PART B OF THE REVERSE SIDE OF THIS FORM (EXAMINING DOCTOR OR OPTOMETRIST INFORMATION) AND SIGN YOUR NAME. PLEASE RETURN THE COMPLETED FORM TO YOUR PATIENT.
DISPENSER OF MATERIAL	PLEASE COMPLETE PART C OF THE REVERSE SIDE OF THIS FORM (SUPPLIER INFORMATION) AND RETURN THE COMPLETED FORM TO THE PATIENT.

Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

MAIL COMPLETED FORM TO:

HEALTHPLEX, INC.
333 EARLE OVINGTON BLVD., SUITE 300
UNIONDALE, NEW YORK 11553-3608
800-468-0600