Mail Claim Form To:

MEDICAL MUTUAL
Your healthcare partner since 1934

Medical Mutual
P.O. Box 6018
Cleveland, Ohio 44101-1018

[redacted]

VISION CLAIM FORM

PART I PATIENT AND CERTIFICATE HOLDER INFORMATION *(please print or type)*

1. Certificate Holder's name _____
   Address _____
   City _____
   State _____ Zip _____
   Phone (___) _____

2. Patient (first name, middle initial, last name)

3. Certificate Holder's ID number:
   _____
   Medical Mutual Plan code: (last 3 digits)
   _____
   (Numbers can be found on Certificate Holder's ID card.)

4. Group name: NOrdonia Hills City Schools

5. Group number: 418470

6. Patient's date of birth / / Age

7. Patient's relation to Certificate Holder
   self (male) 1 ☐ self (female) 2 ☐ husband 3 ☐
   wife 4 ☐ son 5 ☐ daughter 6 ☐
   other male dependent 7 ☐ other female dependent 8 ☐

8. Is patient full-time student 19 years of age or older?
   ☐ yes ☐ no
   Name of school:

9. Was condition related to:
   A. Employment ☐ yes ☐ no
   B. Accident ☐ yes ☐ no
   Date of Onset: _____

10. ****IMPORTANT****
    If the patient is covered by any other group or non-group health insurance, including Medical Mutual, please complete this section.
    Name of other employer _____
    Address of other employer _____
    Name of other person employed _____
    Birthdate of other person employed _____
    Relationship to patient _____
    Other health care plan _____
    If the patient is a child and parent's are divorced, please answer the following:
    a. Which parent has custody of the patient? _____
    b. Is there a court decree that states which parent is responsible for medical bills? ___ yes ___ no. If yes, please attach a copy of the court decree.

11. Is the patient eligible for Medicare? ☐ yes ☐ no

12. Describe the illness, injury or symptom: _____
    _____
    _____
    Date symptom first appeared: _____

5a. I authorize release of any information relative to this claim to be used by Medical Mutual or a review agency with which it has contracted solely for the purposes of determining reimbursement.

_____ DATE: _____
(Signature of Certificate Holder or Spouse)

PART II PHYSICIAN OR PROVIDER INFORMATION *(to be completed by physician or provider only)*

OFFICE SERVICES

Date of examination / /

Service Description	FEES
TOTAL OFFICE FEES	

Refraction ☐ yes ☐ no

OPTICAL STYLE

☐ Glass ☐ Plastic ☐ Other
☐ One eye ☐ Both eyes

CONTACT LENSES

☐ Due to cataract surgery ☐ Other
☐ To obtain 20/70 vision

OPTICAL CHARGES (Date of service / /)

Lens	(L) Acquisition fee	(R)	(L) Dispensing fee	(R)
Single vision				
Bifocal				
Trifocal				
Lenticular				
Tint				
Type _____				
Photochromatic				
Contact lenses				
Frames				
Options				

SUBTOTAL: _____
TAX: _____
OPTICAL CHARGES TOTAL: _____

I certify that the services were performed by me or in my presence under my supervision.

Physician/provider name _____
Address _____
City _____ State _____ Zip _____
Provider Tax ID _____
▶ Signature _____

MED/SURG 006 R5/88
5004 R6/01
Medical Mutual of Ohio®

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