SEND TO: **Benefit Administrators, Inc.**
1250 Tower Lane..
Erie, PA 16505
Phone: (814) 454-0167 Fax: (814) 461-9402
Email: thr.hb.admin@hubinternational.com

VISION BENEFITS CLAIM FORM

(PART A) TO BE COMPLETED BY EMPLOYEE

Name of Employee	Social Security # :	Name of Employer	
Employee Address	**City and State**	**Zip code**	**Date of Birth**
Patient's Full Name	**Relation to Employee**	**Date of Birth**	**Is this Claim Related to an Injury?** ☐ Yes ☐ No

Is the Patient Covered by any Other Vision Insurance Plan? Yes ☐ or No ☐	If Yes, Give Name of Carrier, Carrier Address, Group Number and Identification Number:

I authorize the benefits payable for this claim to be paid directly to the provider in **Part B of this form**, otherwise payable to me.

_____ _____
Signature of Employee Date

I acknowledge that this claim is not for the treatment of any occupational accident or third party injury and I hereby authorize any of the undersigned to disclose any necessary information related to the processing of this claim.

_____ _____
Signature of Employee Date

(PART B) TO BE COMPLETED BY OPTOMETRIST, OPTHALMOLOGIST, OPTICIAN (PLEASE PRINT)

Diagnosis: ☐

DATE OF SERVICE	Procedure Code (CPT or HCPS)	DESCRIPTION	AMOUNT CHARGED

Name and Address of Provider of Services:	Tax Id Number:	Phone Number:

Providers Signature: _____ **Date:** _____