pai

Attention: Tausha Walls
PO Box 6927
Columbia, South Carolina 29260

VISION CLAIM FORM

Before completing this form, see reverse for instructions. Use a separate claim form for each patient.

FOR OFFICE USE ONLY

GROUP #:

1. Member's Identification Number
2. Member's Name — First — M. — Last
3. Home Telephone Number Area Code
4. ☐ Check If new address
5. Member's Address — Street — Apt. No. — City — State — Zip Code
6. Employer's Name and Address
7. Patient's Name — First — M. — Last
8. Patient's Birthdate Mo. Day Yr.
9. Sex ☐ Male ☐ Female
10. Relationship to Member ☐ Self ☐ Spouse ☐ Child ☐ Other
11. Diagnosis or condition requiring treatment.
12. Was any treatment required as the result of accidental injury? ☐ Yes ☐ No
    Was another person at fault? ☐ Yes ☐ No If yes, please attach a statement explaining details of accident to this form.
13. Was any injury or illness work-related? ☐ Yes ☐ No If yes, was a Workers Compensation Claim filed? ☐ Yes ☐ No
14. Is the patient covered by Medicare Health Insurance, Part A? ☐ Yes ☐ No Or by Supplemental Medical Insurance, Part B? ☐ Yes ☐ No
    If yes, please complete the following: Part A: HIB Number _____ Part B: HIB Number _____
15. Is the patient covered under any other group health insurance plan? ☐ Yes ☐ No
    If yes, please complete the following:
16. Name and Address of Other Insurance Company: _____
    b. Name of Policyholder: _____ Relationship to Patient: _____
    Policy Number: _____ Effective Date: _____
    Name and Address of Employer: _____

Provider should complete shaded areas – Otherwise, member must attach itemized bills.

16.

Procedure Code	Exam
92014	Visual exam.
92015	Refraction

Procedure Code	Frames
V2020	Frames
V2100	Single vision lenses
V2200	Bifocals
V2300	Trifocals
V2500	Contact Lenses

17. To be completed if contacts are medically required. ☐ Surgery Date: _____
☐ Other necessity – visual acuity in better eye corrected to: ___ with glasses ___ with contacts.

18.

Line	Date of Service	Procedure Code (from above)	Provider Number	Diagnosis	Med. Nec.	Charge	EOB
1							
2							
3							
4							
	Total Lines			Total Charge			PE / MSG / AUTH

19. Provider Name _____
Street Address _____
City and State _____

Signature of Provider

(I hereby certify that the procedures as indicated above have been completed by me or under my direct supervision.)

Date _____ Provider's Signature _____

(Not required if filed by member.)

20. CERTIFICATION OF MEMBER

I certify that the above information is correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider which participated in any way in my care and treatment to release to Planned Administrators, Inc. any medical information which they in their judgment deem necessary to the adjudication of this claim.

Date _____ Member's Signature _____

(Not required if filed by provider.)

(Rev. 8/2020

FILING TIPS

If entire claim is completed by the member an itemized bill from the provider must accompany the claim form.

MAKE SURE EVERY ITEMIZED BILL SHOWS THE FOLLOWING:

* Name and Address of provider or supplier rendering services.
* Type of each service or supply.
* Date each service or supply was received.
* Amount charged for each service or supply.
* Patient's Name.

Mail completed claim form and itemized bills (if necessary) to:

Planned Administrators, Inc.
Attention: Tausha Walls, Customer Service Supervisor
PO Box 6927
Columbia, SC 29260

Telephone: 803-462-3210
Fax: 803-264-6154
Email: sf_claims@paisc.com

SPECIFIC INSTRUCTIONS FOR COMPLETING ITEMS 1 THROUGH 20 ON THIS FORM
(* indicates provider completion)

1. Member's Identification Number: Number appearing on Identification Card.
2. Member's Name: Name appearing on Identification Card.
3. Home Telephone Number: Area code and number.
4. Check this block if address is new and you want our records corrected.
5. Member's Address: Complete mailing address.
6. Employer's Name and Address: Do not complete if you hold an individual contract.
7. Patient's Name: Patient's first, middle initial and last name. Please do not use nickname. Always use the same name when filing, e.g., Mary J. always file as Mary J.
8. Patient's Birthdate: Patient's month, day and year of birth.
9. Patient's Sex: Check appropriate box.
10. Patient's Relationship to Member: Check appropriate box. If other, please specify such as "foster child," "student," etc.
11. Diagnosis: Indicate condition for which all treatment was rendered in this section, or indicate by charge on itemized statement for what condition treatment was given.
12. Accidental Injury: Check appropriate box. Give date of accident. If another person was at fault, attach a statement explaining details of the accident.
13. Work-related: Check appropriate box.
14. Medicare Healthcare Benefits: If the patient is covered by Medicare Health Insurance, Part A or Supplemental Medical Insurance, Part B, please complete this section.
15. Other Health Insurance Coverage: If patient is covered under any other group health insurance plan, this section should be completed in as much detail as possible. If any benefits have been paid by the other insurance, please attach a copy of their Notice of Payment.

*16. To be completed by the provider.
*17. To be completed by the provider.
*18. To be completed by the provider using procedure codes indicated in item 16.
*19. Signature – Complete name and address of provider and obtain provider's signature.
20. Signature – Signature of patient (unless minor) and member.