How to File Your Claim:
1. You complete **Part A**
2. Have your Physician or Optometrist complete **Part B**
3. Have the Supplier complete **Part C**
4. Attach a copy of itemized statement
5. Send the completed form to Primary Plus Optix Vision Plan

CLAIM FOR VISION CARE BENEFITS
INDEMNITY PLAN

MIAMI DADE COUNTY GOVERNMENT

Mail completed form to:
Optix Vision Plan
Attn: Vision Claims
PO Box 14313
Lexington, KY 40512-431

Phone: (800) 393-2873
Business Hours: 8:00am-6:00pm
Monday-Friday

PART A	**PATIENT & INSURED INFORMATION**	Claim Number_____
PATIENT'S NAME (First, Middle, Last)	2. PATIENT'S BIRTHDATE (Month-Date-Year)	3. EMPLOYEE'S NAME (First, Middle, late) □ Active □ Retired
4. EMPLOYEE ADDRESS (Street, City, State, Zip)	5. EMPLOYEE NUMBER	6. EMPLOYEE SOCIAL SECURITY NUMBER
7. IS THE PATIENT A CHILD AGE 19 OR OLDER? □ Yes □ No	8. PATIENT SEX □ MALE □ FEMALE	9. PATIENT RELATIONSHIP TO INSURED: □ SELF □ SPOUSE □ CHILD □ OTHER
10. IS THE PATIENT COVERED BY ANY OTHER INSURANCE COVERAGE? If so, please enter NAME OF POLICYHOLDER, INSURANCE COMPANY NAME AND ADDRESS, and POLICYHOLDER ID NUMBER.	11. WAS THE CONDITION RELATED TO AN ACCIDENT? □ YES □ NO	12. ARE ANY VISION SERVICES PROVIDED BY A HEALTH MAINTENANCE ORGANIZATION? □ YES □ NO

I hear by authorize the provider of vision care services and/or supplies to release any information requested with respect to this claim and the attached bills. I certify that the information furnished by support of this claim is true and correct.
EMPLOYEE SIGNATURE:_____ DEPENDENT SIGNATURE(If patient is a minor):_____

Date:_____

PART B	**EXAMINING PHYSICIAN**	

1. DIAGNOSIS:_____
2. DATE OF SERVICE:_____ EXAM? □ YES □ NO CONTACT LENS EXAM? □ YES □ NO
3. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? □ YES □ NO DO FRAMES NEED CHANGING? □ YES □ NO
   AXIS CHANGE:_____ DEGREE DIOPTOR, SPHERE OR CYNLINDER CHANGE_____
   WILL LENSES IMPROVE VISUAL ACUITY BY AT LEAST ONE LINE ON A STANDARD CHART? □ YES □ NO
4. ARE ANY OF THESE CHANGES COVERED BY ANOTHER INSURANCE, GOVERNMENT, OR WORKERS COMPENSATION? □ YES □ NO
   IF YES, PLEASE GIVE NAME OF OTHER INSURANCE COMPANY AND NAME OF GROUP:_____
5. CHARGE FOR THIS EXAMINATION $_____ AMOUNT PAID BY EMPLOYEE $_____

I HEAR BY CERTIFY THAT THE ABOVE STATEMENT ACCURATELY DESCRIBES THE SERVICES RENDERED AND THAT I AM AN _____ (type of physician)

MUST BE FURNISHED UNDER AUTHORITY OF LAW

SOCIAL SECURITY NUMBER:_____ EMPLOYER ID NUMBER:_____

PHYSICIAN NAME :_____ DATE :_____ SIGNATURE:_____

ADDRESS (Street, City, State, Zip):_____ PHONE:(_____)_____

PART C	**SUPPLIER STATEMENT**	

THE FOLLOWING LENSES AND/OR FRAMES WERE ORDERED ON _____FOR THE ABOVE PATIENT AS PRESCRIBED ON _____BY MYSELF OR BY DR. _____

MATERIALS SUPPLIED	□ PLASTIC	□ GLASS
LENS TYPE	NUMBER OF LENS	CHARGE
□ SINGLE VISION	_____	$_____
□ BIFOCAL	_____	$_____
□ TRIFOCAL	_____	$_____
CONTACTS □ HARD □ SOFT □ DISPOSABLE	_____	$_____
□ TINT NUMBER	_____	$_____
□ OTHER	_____	$_____

IS THERE ANY OTHER INSURANCE WHICH COVERS THESE CHARGES?
□ YES □ NO

IF YES, PLEASE PROVIDE NAME OF INSURANCE COMPANY AND GROUP:
_____

AMOUNT PAID BY EMPLOYEE: $_____

NAME OF SUPPLIER: _____

SOCIAL SECURITY NUMBER:_____ EMPLOYER NUMBER:_____

ADDRESS: _____ PHONE:(_____)_____

SIGNATURE:_____

TITLE:_____ DATE:_____

ANY PERSON KNOWINLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACTS, MATERIALS THERETO IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

VISION CARE BENEFITS ARE PAYABLE ONLY TO THE MEMBER AND ARE NOT ASSIGNABLE.