Alliance Coal Health Plan

Claims Address:
PO Box 1950
Tulsa, OK 74101-1950

VISION CLAIM FORM

Group Number: 2008ALC

Claim submitted with completed Alliance Coal Vision Claim Form is for (circle one) ***Employee*** ***Spouse*** ***Dependent***

PLEASE COMPLETE FORM COMPLETELY. AN ALLIANCE COAL VISION CLAIM FORM MUST BE COMPLETED FOR EACH CLAIM SUBMITTED. ATTACH ALL BILLS AND CORRESPONDENCE.

EMPLOYEE'S INFORMATION

Employee Name ______________________

Date of Birth ______________________

Member ID # (example: ACZ8300XXXXX-XX) ______________________

Gender (check one) ☐ Male ☐ Female

Are you currently employed? (check one)
☐ Yes ☐ No

If yes, give name and address of employer
____

SPOUSE'S INFORMATION

Spouse Name ______________________

Date of Birth ______________________

Member ID # (Example: ACZ8300XXXXX-XX) ______________________

Gender (check one) ☐ Male ☐ Female

Are you currently employed? (check one)
☐ Yes ☐ No

If yes, give name and address of employer
____
____

DEPENDENT INFORMATION

Dependent Name (First, Middle Initial, Last)	Member ID # (example: ACZ8300xxxxx-xx)	Date of Birth	Gender (Circle One)
			Male Female

ADDITIONAL INFORMATION

Attached vision claim is for
☐ Corrective lenses ☐ Safety glasses

Is patient covered by other insurance?
☐ Yes ☐ No

If yes, complete information at right:

Insured Name ______________________

Insured Company Name ______________________

Policy Number ______________________

Policy Effective Date

AUTHORIZATION FOR RELEASE OF INFORMATION

TO PHYSICIANS OR PRACTITIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, EMPLOYERS, AND OTHER PERSONS OR INSTITUTIONS. This authorizes you to give Alliance Coal Health Plan, or its authorized representative who is employed to assist in the evaluation of my claim, any information, date or records you may have regarding me, my employment or my condition (including records pertaining to psychiatric, drug or alcohol use history, and any disability I may have had). I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to an agency or person employed by Alliance Coal Health Plan. I understand I have the right to request a copy of this authorization and that a copy will be sent to me if requested. A photocopy of this authorization may be accepted as effective and valid as the original. By signing this form, I submit my annual information review and initial claim authorization. I understand that claims submitted under this authorization will be processed subject to continued proof of eligibility and all plan provisions. I verify that the information on this entire form is correct.

Patient/Authorized Person's Signature______________________ Date ______________

Employee's Signature______________________ Date ______________

Employee's Mailing Address ______________________
Street City State Zip