

**VISION CARE CLAIM FORM**



Please Return Completed Claims To:  
 CINUP  
 491 Portage Avenue  
 Winnipeg, MB R3B 2E4  
 Phone: 1-800-665-1234  
 Fax: 1-877-786-3889

**INSTRUCTIONS:**

- THIS FORM IS TO BE USED FOR VISION CARE BENEFITS FOR CORRECTIVE EYEGLASSES/CONTACT LENSES AND EYE EXAMINATIONS.
- BENEFITS PAYABLE SHALL BE DETERMINED BY THE MAXIMUMS AND FREQUENCY LIMITATIONS CONTAINED IN THE COVERAGE AGREEMENT.
- PLEASE COMPLETE ALL SECTIONS OF THE CLAIM FORM.
- PLEASE ATTACH AN ITEMIZED RECEIPT OR INVOICE.
- RECEIPTS WILL NOT BE RETURNED - PLEASE KEEP COPIES FOR YOUR RECORDS. LEGIBLE PHOTOCOPIES MAY BE SUBMITTED IN PLACE OF ORIGINALS.

<b>TO BE COMPLETED BY EMPLOYEE:</b>				(PLEASE PRINT CLEARLY)			
CERTIFICATE NO. 1012345		POLICY 30101		SURNAME OF PATIENT SMITH		GIVEN NAME AND INITIAL OF PATIENT BOBBY	
EMPLOYEE ADDRESS 67 MARKET ST.		CITY/TOWN WINNIPEG		PROVINCE MB		DATE OF BIRTH DAY MONTH YEAR 30 11 72	
EMPLOYEE NAME: LAST SMITH		FIRST MARY				DATE OF BIRTH DAY MONTH YEAR 03 11 73	
<b>PRESCRIPTION EYEGLASSES/CONTACT LENSES</b> PRESCRIBED BY: <input type="checkbox"/> OPHTHALMOLOGIST <input checked="" type="checkbox"/> OPTOMETRIST <input type="checkbox"/> PHYSICIAN DATE OF PURCHASE: 15 / 05 / 08 AMOUNT BILLED: \$ 270.00				ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER VISION CARE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE FOLLOWING: CONTRACT HOLDER OF OTHER PLAN _____ BIRTHDATE: _____ / _____ / _____ EMPLOYER _____ EMPLOYER'S INSURANCE CO. _____ POLICY OR CONTRACT NUMBER _____ IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM FIRST INSURER AND COPIES OF THE RECEIPTS.			
<b>EYE EXAMINATIONS</b> EXAM COMPLETED BY: <input type="checkbox"/> OPHTHALMOLOGIST <input checked="" type="checkbox"/> OPTOMETRIST DATE OF SERVICE: 12 / 05 / 08 AMOUNT BILLED: \$ 30.00							
<b>LASER EYE SURGERY</b> DATE OF SERVICE: _____ / _____ / _____ AMOUNT BILLED: \$ _____							
<b>ASSIGNMENT OF BENEFITS</b>							
IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER: PROVIDER NUMBER _____ NAME _____ ADDRESS _____ _____ POSTAL CODE _____ I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE PROVIDER FOR THE COST OF TREATMENT. EMPLOYEE SIGNATURE _____				<b>IF CLAIMANT IS A DEPENDENT CHILD OVER THE AGE OF 18 PLEASE COMPLETE THE FOLLOWING:</b> 1. AGE OF CHILD _____ 2. IS HE/SHE MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE OF MARRIAGE DD MM YY 3. IS HE/SHE EMPLOYED FULL-TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE FULL TIME EMPLOYMENT STARTED DD MM YY 4. IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL COLLEGE, OR UNIVERSITY? <input type="checkbox"/> YES <input type="checkbox"/> NO 5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I AGREE THAT THIS CLAIM IS TRUE AND CORRECT AND AGREE THAT IT SHALL BE SUBJECT TO THE PROVISIONS OF THE POLICY.							
SIGNATURE OF INSURED <i>M. Smith</i>				DATE 05/15/08			
<b>FOR GLASSES OR CONTACT LENSES, ATTACH PRESCRIPTION OR HAVE SUPPLIER COMPLETE AT PLACE OF PURCHASE:</b>							
<b>PRESCRIPTION DETAILS:</b> SPHERE: R _____ L _____ CYLINDER: R _____ L _____ AXIS: R _____ L _____ PRISM 1: R _____ L _____ BASE 1: R _____ L _____ PRISM 2: R _____ L _____ BASE 2: R _____ L _____ ADD: R _____ L _____				ARE THESE CORRECTIVE LENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO IS THIS A PRESCRIPTION CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO COST: LENSES \$ _____ FRAMES \$ _____ REPAIRS \$ _____ TINTS/COATINGS \$ _____ CONTACT LENSES \$ _____ TOTAL COST \$ _____			
<input type="checkbox"/> Non-Status <input checked="" type="checkbox"/> Status If "Status", complete the following: Total Amount of Claim: \$ 270.00 If the amount paid by NIHB is nil, please indicate why _____ Less any reimbursement through NIHB: \$ 100.00 <input checked="" type="checkbox"/> Reached annual limit Balance owing: \$ 170.00 <input type="checkbox"/> Other, please provide details _____							
DATE 05/15/08				I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED. SUPPLIER'S SIGNATURE: <i>X</i>			