GOODWILL OF CENTRAL & NORTHERN ARIZONA

FUSION Highlight Sheet

Ameritas

CLAIM FORM

PLEASE BE AS THOROUGH AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS FORM. ERRORS OR OMMISSIONS MAY DELAY CLAIM PAYMENTS. Claims Must Be Submitted Within 90 Days from Date of Service.

TO BE COMPLETED BY THE CARDHOLDER

1. PATIENT'S NAME (*Last, First, Middle*)	2. CARDHOLDER'S GROUP # **35327**	3. CARDHOLDER'S ID#	
4. PATIENT'S BIRTH DATE	5. PATIENT'S SEX ☐ MALE ☐ FEMALE	6. RELATIONSHIP TO CARDHOLDER ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	7. CARDHOLDER'S NAME (*Last, First, Middle*)
8. CARDHOLDER'S ADDRESS (*No., Street, City, State and Zip Code*)		9. HOME NUMBER ( )	WORK NUMBER ( )
10. NAME OF INSURANCE CARRIER **Ameritas**	11. NAME OF EMPLOYER **Goodwill of Central & Northern AZ**	12. CARDHOLDER'S STATUS ☐ ACTIVE ☐ RETIRED ☐ HOURLY ☐ SALARIED	13. CARDHOLDER'S BIRTH DATE
14. PATIENT IS COVERED FOR VISION CARE BY ANOTHER PLAN ☐ YES ☐ NO IF YES, PLEASE COMPLETE BOXES 15 THROUGH 16		15. NAME AND ADDRESS OF THE OTHER CARRIER	
16. POLICY HOLDER'S NAME	17. RELATIONSHIP TO CARDHOLDER ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	18. POLICY HOLDERS' DATE OF BIRTH	19. POLICYHOLDER'S S.S. #/GROUP

SIGNATURE OF CARDHOLDER _____ DATE SIGNED _____

PLEASE CHECK ALL ITEMS BELOW THAT APPLY TO THE SERVICES RENDERED BY YOUR EYE CARE PROVIDER

DATE OF SERVICE _____

- ☐ EXAM
- ☐ CONTACT LENS FITTING/EXAM
- ☐ CONTACT LENSES
- ☐ EYE GLASS LENSES
- ☐ SINGLE VISION
  - ☐ BIFOCAL
  - ☐ TRIFOCAL
  - ☐ PROGRESSIVE (NO LINE BIFOCAL)
  - ☐ OTHER _____
- ☐ FRAME

PLEASE SUBMIT THIS FORM WITH YOUR ITEMIZED RECEIPT (S) TO THE FOLLOWING

Send claims to: Ameritas Group Claim Office
P.O. Box 82520
Lincoln, NE 68501
Toll Free (800) 487-5553
www.ameritas.com

$100 Flat Max

☐ Check to send payment directly to provider.

Member Signature _____