PBA
Professional Benefit Administrators, Inc.

VISION CLAIM FORM

Send all bills to:
Professional Benefit Administrators, Inc.
P. O. Box 4687
Oak Brook, IL 60522-4687
800-435-5694

INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

- Return the completed form to the address shown above with all the original copies of your bills.
- Bills must show the patient's name, the date and type of service, the charge, the diagnosis, and the social security number or Federal Tax I.D. number of the provider.

Complete for all claims

Company Name: **NSEBC**	Patient Name:	
Employee name:	Date of birth:	ID#:
Home Address:		Phone:
Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed		
Spouses Name:	Date of birth:	ID#:
Is Spouse Employed? ☐ Yes ☐ No If yes, Company Name:		
Address:		Phone:

Are you or your dependents entitled to benefits from any other Group Insurance Plan or Group Vision Plan? ☐ Yes ☐ No If yes, please identify:	A. Identify family member insured under other plan:
	B. Name(s) and address of their insurance company and/or organization
	C. Group Policy Number

Complete if claim is for dependent

Name:	Relationship:	Date of birth:
Home address if different from employee:		
Is dependent employed? ☐ Yes ☐ No	Name of Employer:	
Address:		Phone:

CERTIFICATION & AUTHORIZATION TO RELEASE INFORMATION : I certify that these statements and answers are true to the best of my knowledge and belief. I hereby agree to reimburse this plan to the extent that benefits are provided under any Workers' Compensation law, similar legislation, and/or any settlement related to such coverages.

I hereby authorize any insurance company, provider, or any other organization to release all information to PBA, Inc., which may have a bearing on the benefits payable under this plan. A photocopy of this authorization will be considered as effective and valid as the original, and will be valid for one year from the date below.

Date: _____ Signature of Employee: _____ Signature of Spouse: _____
(if claim is on spouse)