ADN ADMINISTRATORS

VISION CLAIM FORM
Eligibility Verification 1-888-236-1100
MAIL CLAIM FORM TO: ADN
PO BOX 610
SOUTHFIELD, MI 48037

GROUP NAME:____

EMPLOYEE AND PATIENT PORTION

EMPLOYEE'S CONTRACT NUMBER/SSN
EMPLOYEE FIRST & LAST NAME
DATE OF BIRTH

EMPLOYEE'S ADDRESS

PATIENT NAME
DATE OF BIRTH

PATIENT'S RELATIONSHIP TO EMPLOYEE
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

OTHER INSURANCE COVERAGE
IS PATIENT COVERED BY ANOTHER VISION PLAN? YES ☐ NO ☐
IF YES, PROVIDE NAME AND ADDRESS OF CARRIER

SOCIAL SECURITY NUMBER OF OTHER INSURED
NAME OF EMPLOYER

OTHER INSURED'S NAME
DATE OF BIRTH

IS THIS CONDITION CAUSED BY EMPLOYMENT? EXPLAIN

DOES CLAIM INVOLVE INJURY? YES ☐ NO ☐
WAS PATIENT INJURED AT WORK? YES ☐ NO ☐
DATE AND TIME OF INJURY____

I AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED DURING MY EXAM OR TREATMENT.

SIGNED (EMPLOYEE OR PATIENT) DATE

I AUTHORIZE PAYMENT OF BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER OF SERVICES DESCRIBED BELOW.
DO NOT SIGN IF YOU HAVE PAID UP FRONT FOR SERVICES

SIGNED (EMPLOYEE OR PATIENT) DATE

TO BE COMPLETED BY SERVICE PROVIDER OR ATTACH A DETAILED RECEIPT OR CLAIM

DATE(S) OF SERVICE	PROCEDURE CODE	DESCRIPTION	DIAGNOSIS	CHARGE

BILLING ENTITY AND ADDRESS

PHONE NUMBER -

TAX ID NUMBER -

PHYSICIAN'S LICENSE NUMBER -

SIGNATURE OF TREATING PHYSICIAN DATE