Vision Claim Form -AOB

Employer____

Employee ____

Social Security No _____-_____-_____ Member ID _______________ Birth Date ___________________

Address ____

City______________________________ State _______________ Zip _________________

Phone No ___________________________ E-mail _________________________________

Patient Name____

Relationship to Employee _____________________________ Birth Date ___________________

If a child over the age of 18, attach proof of full-time student status.

Provider____

Tax ID No (only required if check paid directly to provider) ___________________Phone No.______________

Address ____

City______________________________ State _______________ Zip _________________

Was treatment a result of an accident? ☐Yes ☐No

Was treatment for cosmetic care? ☐Yes ☐No

Please attach a copy of the original itemized bill.

Under penalty of law, I agree to the following: This claim occurred while the patient was covered by this plan. The attached bill is an original and unaltered bill.

Employee Signature _________________________________ Date ______________________

Assignment of Benefits to the Vision Care Provider

I hereby assign my benefits under this plan to the vision care provider. I understand that my payment under the plan will be mailed to my vision care provider directly and my vision care provider may require payment at time of service or may bill me for amounts not covered under the plan.

Employee Signature _________________________________ Date ______________________

FOR FASTEST SERVICE, PLEASE FAX THIS FORM
AND SUPPORTING DOCUMENTATION TO: 1-678-258-8299
Or scan and e-mail to: claims@simple.us
Or mail to: Simple, Claims Department, 1745 North Brown Road, Suite 400, Lawrenceville, GA 30043
Customer Service: 800-270-4158

REMEMBER TO INCLUDE A COPY OF THE ORIGINAL ITEMIZED BILL.
Keep a copy for your records.