Nippon Life Benefits®

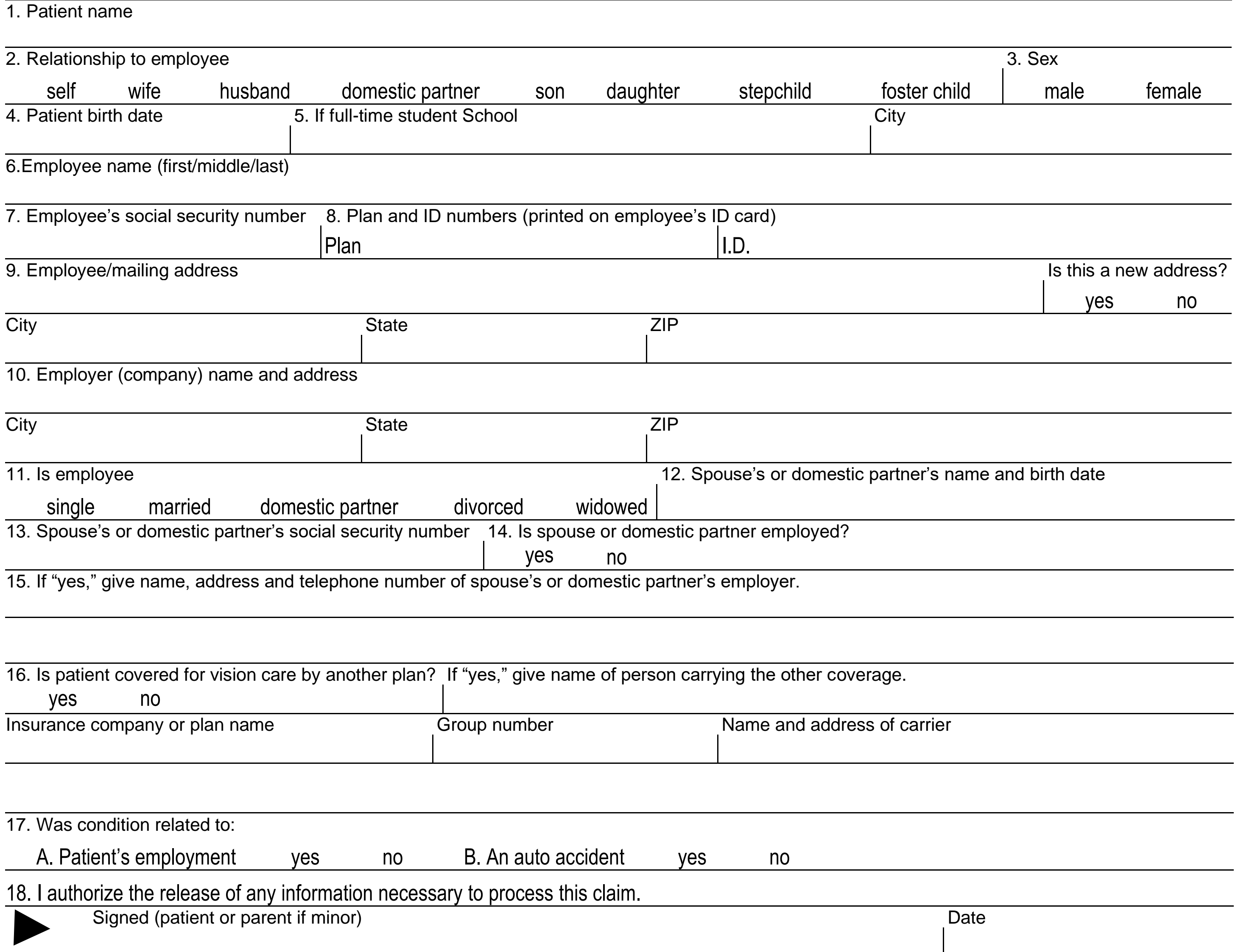
Nippon Life Insurance Company
of America
Claim Center
P.O. Box 4387
Clinton, IA 52733

Vision Care Claim - CA

Please mail completed form to the address above.

See Page 2 for Claim Filing Instructions.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.



Part A. - Patient & Employee Information

1. Patient name

2. Relationship to employee
self wife husband domestic partner son daughter stepchild foster child

3. Sex
male female

4. Patient birth date

5. If full-time student School | City

6.Employee name (first/middle/last)

7. Employee's social security number

8. Plan and ID numbers (printed on employee's ID card)
Plan | I.D.

9. Employee/mailing address

Is this a new address?
yes no

City | State | ZIP

10. Employer (company) name and address

City | State | ZIP

11. Is employee
single married domestic partner divorced widowed

12. Spouse's or domestic partner's name and birth date

13. Spouse's or domestic partner's social security number

14. Is spouse or domestic partner employed?
yes no

15. If "yes," give name, address and telephone number of spouse's or domestic partner's employer.

16. Is patient covered for vision care by another plan? yes no

If "yes," give name of person carrying the other coverage.

Insurance company or plan name | Group number | Name and address of carrier

17. Was condition related to:
A. Patient's employment yes no B. An auto accident yes no

18. I authorize the release of any information necessary to process this claim.

Signed (patient or parent if minor) | Date

Part B. - Examining Physician or Optometrist's Information

Indicate diagnosis, nature of disease, injury or vision disorder

If contact lenses, would the visual acuity be corrected to 20/70 in the better eye by use of conventional lenses? yes no

Report of services or attach itemized bill. (If previous form submitted to this carrier, you need to show only dates and services since last report.)

Date of Service	Services Rendered	Charges
		$
		$

Physician's or optometrist's name		Phone number	Total charges $
▶ Physician's or optometrist's address (street, city, state, ZIP code)		Federal I.D. number or tax I.D. number	Amount paid $
▶ Physician's or optometrist's signature	Date	Your patient's account number	Balance due $

Authorization to pay - Sign only if you want benefits paid directly to physician or optometrist.

I authorize payment of vision care benefits to the physician or optometrist described in Part B.

▶ Employee or authorized person's signature	Date

Part C - Supplier Information (To be Completed by Dispenser of Prescription other than Prescribing Physician)

Type	Date of purchase	Date of delivery to patient	Charges
Lenses			
Frames			
Contacts			
Tint			
Coating			
Oversizing			
Other			
			Total charges $

Supplier name and address (street, city, state, ZIP code)

Supplier phone number

Federal I.D. number or tax I.D. number

▶ Signature of supplier		Date
Patient's account number	Amount paid $	Balance due $

Type of lenses:

☐ single vision ☐ bifocal ☐ trifocal ☐ lenticular

☐ contact lenses ☐ disposable contact lenses
number of months supplied: _________

Authorization to pay - Sign only if you want benefits paid directly to supplier.

I authorize payment of vision care benefits to the supplier described in Part C.

▶ Employee or authorized person's signature	Date

☐ **Payment receipt or cash register receipt for prescription attached (See item 5 below.)**

Instructions to Employee

(1) Complete questions 1 through 18 (**Part A**) on Page 1 and sign and date line 18.
(2) Have patient's physician or optometrist complete the **Examining Physician or Optometrist's Information** section (**Part B**) on Page 2.
(3) Have patient's supplier (if other than examining physician or optometrist) complete the **Supplier Information** section (**Part C**) on Page 2.
(4) Attach itemized bills for expenses not shown on Page 1. If you want benefits paid directly to the physician or optometrist, sign the **Authorization to pay** in section (**Part B**) on Page 2. If you want benefits paid directly to the supplier (if other than examining physician or optometrist), sign the **Authorization to pay** in section (**Part C**) on Page 2.
(5) Attach payment receipt or cash register receipt to claim form if prescription is being filled by someone other than the examining physician or optometrist.