BlueCross BlueShield Nebraska

This form should only be used when filing claims to your local Blue Cross and Blue Shield Plan.

VISION CLAIM FORM

Please type or print clearly.
Check with the physician to verify the charges have not been submitted.
One claim form per patient per provider.
See reverse side for instructions.

BLUE CROSS AND BLUE SHIELD OFFICE USE ONLY

SUBSCRIBER INFORMATION

1. Blue Cross and Blue Shield ID Number:
(ALPHA PREFIX)

2. Subscriber's Home Phone Number:
(AREA CODE) (TELEPHONE NUMBER)

3. Subscriber's Name:
(LAST NAME) (FIRST NAME) MI

4. Subscriber's Address: Street:

City: State: Zip:

PATIENT INFORMATION

5. Patient's Name:
(LAST NAME) (FIRST NAME) MI

6. Patient's Relationship to Insured:
☐ Self ☐ Spouse ☐ Child ☐ Other _____

7. Sex:
☐ Male ☐ Female

8. Date of Birth:
M M D D Y Y

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE DIAGNOSIS TO PROCEDURE BELOW)

PLEASE SELECT THE APPROPRIATE DIAGNOSIS AND PROCEDURE CODE FOR USE IN SECTION BELOW.

Procedure Codes:

92002 Eye Exam
(Intermediate, new patient)
92004 Eye Exam
(Comprehensive, new patient)
92012 Eye Exam
(Intermediate, established patient)
92014 Eye Exam
(Comprehensive, established patient)
92015 Refraction
92081 Field Exam
92310 Contact Exam Fitting
92326 Replacement of lenses

Frames/Other Options:

V2020 Frames
V2745 Tint (any color)
V2750 Anti-Reflective Coating
V2755 UV Coating
V2760 Scratch Resistance coating (per lens)
V2799 Misc. Vision Service

Lenses:

V2100 Single Vision Lens
V2200 Bifocal Lens
V2299 Specialty Bifocal Lens
V2300 Trifocal Lens
V2520 Soft Contacts
V2510 Gas Permeable contacts
V2521 Toric Lens
V2599 Replacement Lens
V2715 Prism Lens
V2744 Transitional Lens/Tint
V2780 Oversized Lens
V2781 Progressive Lens
V2784 Polycarb Lens
Other _____

Diagnosis:

Z01.00 Encounter for examination of eyes and vision without abnormal findings
Z01.01 Encounter for examination of eyes and vision with abnormal findings
H52.01 Hypermetropia, Right eye
H52.02 Hypermetropia, Left eye
H52.03 Hypermetropia, Bilateral
H52.11 Myopia, Right eye
H52.12 Myopia, Left eye
H52.13 Myopia, Bilateral
H52.211 Irregular astigmatism, Right eye
H52.212 Irregular astigmatism, Left eye
H52.213 Irregular astigmatism, Bilateral
H52.221 Regular astigmatism, Right eye
H52.222 Regular astigmatism, Left eye
H52.223 Regular astigmatism, Bilateral
H52.4 Presbyopia

Provider of Service:

Name: _____ **Tax ID # or NPI #** _____ **Address:** _____

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above named patient.

Subscriber Signature: _____ Date: _____

NOTE

A separate claim form must be completed for each patient and each provider. All information sections must be completed. Please check with your provider of care to see if he or she has already filed any of these charges for you.

Upon completion, mail your vision claim form to:

Blue Cross and Blue Shield of Nebraska
PO BOX 3248
Omaha, NE 68180-0001

SUBSCRIBER INFORMATION

1. Identification number: Enter the identification number and any alpha prefix as shown on your Blue Cross and Blue Shield card. (If you are age 65 or older, this number may not be the same as your Medicare number.)
2. Subscriber's home phone number: The area code and phone number.
3. Subscriber's name: Enter the subscriber's name as shown on your identification card.
4. Subscriber's address: The home address of the subscriber.

PATIENT INFORMATION

5. Patient's name: The patient's full legal name (not nickname) and "Jr." or "Sr." if applicable.
6. Patient's relationship to subscriber: Check the appropriate box to indicate the relationship of the patient to the subscriber.
7. Sex: The sex of the patient.
8. Date of birth: The date of birth of the patient. Provide month, day and year.