BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association.

BLUE CROSS AND BLUE SHIELD OFFICE USE ONLY

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

VISION CLAIM FORM
BlueCard® Program

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.

SUBSCRIBER INFORMATION

1. Blue Cross and Blue Shield I.D. Number:

(ALPHA PREFIX)

2. Subscriber's Home Phone Number:

(AREA CODE) (TELEPHONE NUMBER)

3. Subscriber's Name:

(LAST NAME) (FIRST NAME) M.I.

4. Subscriber's Address: Street:

City: State: Zip:

PATIENT INFORMATION

5. Patient's Name:

(LAST NAME) (FIRST NAME) M.I.

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.

* Place of Service Codes:
11 Provider's Office
12 Patient's Home/Supply House
21 Inpatient Hospital
22 Patient's Home/Supply House

Diagnosis:
1 V72.0 Routine Eye Examination
2 367.0 Hypermetropia (Far-sightedness)
3 367.1 Myopia (Near-sightedness)
4 367.20 Astigmatism
5 367.4 Presbyopia
6 Other (Please specify with valid ICD-9 Code)

Procedure Codes:
1 92002 Eye Examination (Intermediate, New Patient)
2 92004 Eye Examination (Comprehensive, New Patient)
3 92012 Eye Examination (Intermediate, Established Patient)
4 92014 Eye Examination (Comprehensive, Established Patient)
5 92015 Refraction
6 Other (Please specify with valid CPT Code)

A	B	C	D		E	F	G	H
DATE(S) OF SERVICE MM DD YY	*PLACE OF SERVICE	TYPE OF SERVICE	MODIFIER	PROCEDURES, SERVICES, OR SUPPLIES CPT OR HCPCS CODE	DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	LEAVE BLANK

FEDERAL TAX I.D. NUMBER	SSN ☐ EIN ☐	PATIENT'S ACCOUNT NO.	ACCEPT ASSIGNMENT? (for government claims) ☐ YES ☐ NO	TOTAL CHARGES	AMOUNT PAID	BALANCE DUE
				$	$	$

SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
SIGNED DATE		PIN # GRP#

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.