GUARDIAN LIFE LIMITED
LOOKING AFTER LIFE
A MEMBER OF THE GUARDIAN HOLDINGS GROUP

OPTICAL CLAIM FORM
EBD191

MedeCus HEALTH

1. Member No.[1]

TRN[2]

2. PATIENT INFORMATION

Member/Patient's Name (First)[3] MI

(Last)[3]

3. Is patient covered by another Insurance Co.?	3-a. Name and Address of Other Carrier(s)	3-b. Other Group/Policy No.
☐ Yes ☐ No If Yes, complete 3-a and 3-b		

I hereby authorize the release of any information relating to this claim.

Signed (Patient or Parent, if minor) Date

I hereby authorize payment of the Optical benefits directly to the below named Optical provider:

Signed (Patient or Parent, if minor) Date

4. Name of Provider.

5. Address where payment should be remitted.

City

6. Provider TRN:	7. Provider GCT No.:	8. Provider Tel. No.:

Remarks:

Optical Procedures	Procedure Codes *
Single Vision Lenses	V2100
Bifocal Lenses	V2200
Trifocal Lenses	V2300
Contact Lenses	V2500
Lenticular Lenses	V2215
Frames	V2020

* HCPCS 2005

10. TO BE COMPLETED BY OPTOMETRIST/OPHTHALMOLOGIST

Diag. Code	Diagnosis	Description of Service	Description of Service	Procedure	Charge	Amount Paid by Patient
			Examination			
			Type of Lens			
			Frames			
			TOTAL CHARGE			

11. CERTIFICATION - THIS FORM MUST BE SIGNED BY THE PROVIDER OR AUTHORIZED PERSON

I hereby certify that the above services, as indicated by date, have been completed.

Provider Stamp Signature of Provider or Authorized Person Date

PLEASE ATTACH ORIGINAL RECEIPTS TO ENSURE TIMELY PROCESSING OF CLAIMS.

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST SERVICE DATE TO ENSURE PROMPT PROCESSING.

FOR OFFICIAL USE: Index by Member No., TRN, Name of Member