

NORTH AMERICA ADMINISTRATORS

P. O. Box 1984 • Nashville, TN 37202
1826 Elm Hill Pike • Nashville, TN 37210
Fax: 615-255-6654

naa

North America
Administrators

Group Name:		Employee Name:	Social Security #:		
		Address:	Email:		
I Hereby Apply for Benefits for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Unmarried Child		Patient's Name:	Patient's Date of Birth: / /	FEMALE <input type="checkbox"/> MALE <input type="checkbox"/>	
Is Dependent a Student? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	If so, name and address of school (Street, City, State and Zip Code)		Is Dependent carried as an income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does any other employer or organization contribute to, make deductions for, or otherwise participate in any other group program in your or any of your dependent's behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name of dependent _____					
Name and address of plan:		Name and address of other plan:		Plan Number:	

<p>PATIENT'S AUTHORIZED PERSON'S SIGNATURE:</p> <p>I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p> <p>SIGNED _____ DATE _____</p>	<p>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:</p> <p>I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED _____</p>
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TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST			
First Correction? _____ Prescription Change: _____			
One	Two		
<input type="checkbox"/>	<input type="checkbox"/>	Lenses - Single Vision \$ _____	
<input type="checkbox"/>	<input type="checkbox"/>	Lenses - Bifocal \$ _____	
<input type="checkbox"/>	<input type="checkbox"/>	Lenses - Trifocal \$ _____	
<input type="checkbox"/>	<input type="checkbox"/>	Lenses - Lenticular \$ _____	
<input type="checkbox"/>	<input type="checkbox"/>	Lenses - _____	
		<i>Types of Contact Lens</i>	
		<input type="checkbox"/> Disposal <input type="checkbox"/> Regular	
		TOTAL \$ _____	
Exam	\$ _____		
Frames	\$ _____		
TOTAL	\$ _____	Date of Exam _____	
		Doctor's Signature _____	Degree _____ Date _____
		Print or Type Doctor's Name _____	
		Street Address _____	
		City _____	State _____ Zip _____ Telephone No. _____

TO BE COMPLETED BY DISPENSING OPTICIAN (OR ATTACH ITEMIZED BILL)			
Frames _____			
One	Two		
<input type="checkbox"/>	<input type="checkbox"/>	Lenses - Single Vision \$ _____	
<input type="checkbox"/>	<input type="checkbox"/>	Lenses - Bifocal \$ _____	
<input type="checkbox"/>	<input type="checkbox"/>	Lenses - Trifocal \$ _____	
<input type="checkbox"/>	<input type="checkbox"/>	Lenses - Lenticular \$ _____	
<input type="checkbox"/>	<input type="checkbox"/>	Lenses - Cosmetic Contact	
		TOTAL \$ _____	
Frames - Date of Service _____			
LENS - Date of Service _____			
		Provider's Signature _____	Date _____
		Print or Type Provider's Name _____ Tax ID # _____	
		Street Address _____	
		City _____	State _____ Zip _____ Telephone No. _____