SEND COMPLETED FORM TO ☛

NORTH AMERICA ADMINISTRATORS

P. O. Box 1984 • Nashville, TN 37202
1212 Eighth Avenue South • Nashville, TN 37203

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

PATIENT'S AUTHORIZED PERSON'S SIGNATURE:

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.

SIGNED_____ DATE_____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED_____

TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST

First Correction?_____ Prescription Change?_____

One	Two		
☐	☐	Lenses - Single Vision	$_____
☐	☐	Lenses - Biofocal	$_____
☐	☐	Lenses - Trifocal	$_____
☐	☐	Lenses - Lenticular	$_____
☐	☐	Lenses -	$_____

Types of Contact Lens
❒ Disposal ❒ 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 ATTACHED ITEMIZED BILL)

Frames_____

One	Two		
☐	☐	Lenses - Single Vision	$ _____
☐	☐	Lenses - Biofocal	$ _____
☐	☐	Lenses - Trifocal	$ _____
☐	☐	Lenses - Lenticular	$ _____
☐	☐	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.