

PINAL COUNTY VISION CLAIM FORM
Group 0110001

Complete all information and attach original itemized bills.

Submit Claim Form and Bill to: Pinal County Vision Benefits
Ameriben/IEC Group
P.O. Box 7186
Boise, ID 83707

Employee Name _____ Employee ID # _____

Employee Mailing Address: _____
Street

City _____ State _____ Zip Code _____

Patient Name: _____ Patient's Date of Birth _____

Is Patient covered by another Vision Plan? Yes _____ No _____

If Yes – Insurance Carrier _____ Policy # _____

Insurance Carrier Phone Number _____

Physician Name _____

Physician Mailing Address _____
Street

City _____ State _____ Zip Code _____

Physician Phone Number _____

Authorization to release information: I hereby authorize the provider of service to release any information acquired in the course of my examination or treatment.

Insured Signature _____ Date: _____

This claim has been paid in full. Please send reimbursement to insured: Yes _____ No _____