CDCS HEALTH CLAIMS INC.

VISION CLAIM FORM

PART 1 – PATIENT

Last Name First Name

Address Apt.

City Province Postal code

PART 2 – PROVIDER

Unique No. Spec. Patients Account No.

Provider name

Address Postal Code

Phone numbers / fax / email

Date of Service Day	Mo.	Yr.	Description of services – Describe in detail Attach original receipts	Provider Fees	Extra Expenses	Total Charges
			TOTALS			

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Providers Signature

Day/Month/Year

This is an accurate statement of the services performed and the fees charged.
E & OE.

For Provider use only. Additional information and Special Considerations.

For CDCS use only: Claim Number:

I understand that the fees listed in this claim may not be covered by or may exceed my policy Limits. I understand that I am financially responsible for the entire cost of this treatment.
I authorize release of the information contained in this claim form and the communication of information related to the coverage of services described in this form to my insuring company, plan administrator and to the named provider, who will all keep it confidential.

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Signature of Patient or Parent/Guardian

ASSIGNMENT ONLY

I hereby assign benefits payable from this claim directly to the above name provider.

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Signature of Employee/Cardholder

PART 2 – EMPLOYEE/CARDHOLDER

Policy Number/Group Number:

Name of Employer/Policyholder

Employee Certificate Number:

Name of Employee/Cardholder

If student is overage enter School Name and Expected Graduation date:

Spouse ____ Dependent ____ Other (specify) ____

Patient relationship and Date of Birth of Patient (d/m/y)

Are benefits payable for this claim insured by any other group insurance plan? If yes, indicate the name of insurer and their policy number and if applicable your spouses date of birth.

Yes ❑ No ❑ Spouse's date of Birth (d/m/y) ____

If any treatment is required as the result of an accident indicate date of accident and details. (d/m/y). / /

Out-of-Province Claim: Yes ❑ No ❑

If yes, please provide date of departure (d/m/y). / /

and date of departure (d/m/y). / /

I hereby certify that the information give by me is true, correct and complete to the best of my knowledge. ☐

Signature of Employee/Cardholder

Day/Month/Year

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

MAILING ADDRESS: 3-1556 LASALLE BLVD, SUDBURY, ON P3A 1Z7

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