EYEMED SUPERIOR HUMANA BCBS AETNA

VSP Patients, please fill out a different form

Primary's SS# _________-_______-____________

Primary's Name _______________________ DOB______________

Primary's Employer_____________________

Patient's Name ________________________ DOB______________

Relationship to Primary : self spouse child

I authorize Johnson i-Care to release any medical or other information necessary to process this claim. I agree that any charges that are not covered or denied by my insurance will be my responsibility.

SIGNATURE ____________________________ **DATE** ________________

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Eligibility or services Patient is receiving EXAM FIT CONTACTS

Exam Copay________ Fitting Copay______ /_________ Contacts Copay ______

Contact Lens Allowance ______________

% Discount on remaining balance ________________

Authorization # ____________________ Claim # ______________________

Date claim is filed ________________ Tech's initials _______________