Please submit to:

Insight Benefit Administrators

Insight Benefit Administrators LLC

Email or Fax Billing Invoice to:
RA_TPA@Insightba.net or Fax to: (616) 588-5341
Customer Service Phone: 877-827-1414

1. Patient Name	2. Patient Date of Birth	3. Employee Name
4. Employee's Address	5. Patient's Sex ☐ Male ☐ Female	6. Employee Social Security Number
	7. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	8. Employee's Company Name
9. Other Vision Insurance Coverage – Enter Name and Policy Number.	10. Condition Related to: ☐ Patient's employment ☐ Auto Accident: If yes, please provide explanation.	
11. Patient's or Authorized Person's Signature. I Authorize the Release of any Vision Information Necessary to Process this claim. Signed Date	12. I Authorize Payment of Vision Plan Benefits to Undersigned Provider for Services Described below. Signed Date	

☐ Pay Me (Sign Box 11 Only) ☐ Pay Provider (Sign Box 11 & 12)

Provider Information

Charges

Exam: Date of Service _____ $_____
Lenses: Date of Service _____ $_____

Type of Lense(s):
- ☐ Single ☐ Tinted
- ☐ Bifocal ☐ Sunglasses
- ☐ Trifocal ☐ Safety Glasses
- ☐ Other _____

Frames: Date of Service_____ $_____

Contacts: Date of Service_____ $_____

Please state reason for contacts (severe corneal astigmatism, severe corneal scarring, aphakia, or patient prefers contacts, etc.)

_____

Total $_____

Paid $_____

Balance Due $_____

Date	Provider Name	Signature	License #	SSN or Tax ID

Street Address	City	State	Zip Code	Telephone