Please submit to:

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
- Bifocal
- Trifocal
- Other ______________________
- Tinted
- Sunglasses
- Safety Glasses

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

2851 Charlevoix Dr. S.E., Suite 325 Grand Rapids, MI 49546