



HEALTH APPLICATION NETWORK
 P.O. Box 1570
 East Lansing, MI 48823
 1-800-445-2363

FOR HAN VISION USE ONLY

GROUP NAME _____

PATIENT STATEMENT

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F		4. PATIENT BIRTHDATE MO. DAY YEAR			5. FULL TIME STUDENT IF OVER AGE 18 SCHOOL CITY	
6. EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE INITIAL LAST		7. EMPLOYEE SOC. SEC. NO.		8. EMPLOYEE MAILING ADDRESS CITY, STATE, ZIP		9. EMPLOYER (COMPANY) NAME AND ADDRESS				
10. GROUP NUMBER		11. IS YOUR SPOUSE EMPLOYED? YES NO SPOUSE NAME SOCIAL SECURITY NUMBER		12. SPOUSE BIRTHDATE MONTH DAY YEAR		13. NAME AND ADDRESS OF SPOUSE EMPLOYER, ITEM 11				
14. DOES PATIENT HAVE OTHER VISION COVERAGE?		PLAN NAME		GROUP NUMBER						

PROVIDER

15. PROVIDER NAME		20. IS EXAM THE RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES
16. MAILING ADDRESS CITY, STATE, ZIP		21. IS EXAM THE RESULT OF AUTO ACCIDENT?			
		22. OTHER ACCIDENT?			
		23. IS EXAM REQUIRED AS CONDITION OF EMPLOYMENT?			
17. PROVIDER SOC. SEC. NO. OR E.I.N.	18. PROVIDER LICENSE NO.	19. PROVIDER PHONE NO.	24. IF YES TO 20, 21, 22 OR 23 ABOVE, GIVE BRIEF DESCRIPTION AND DATES		

EXAM

25. EXAMINATION RECORD

DESCRIPTION	DATE	CODE	FEE	PLAN ALLOWANCE	PATIENT RESPONSIBILITY
EXAMINATION		92200			
HAVE GLASSES/CONTACT LENSES BEEN PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO					

FRAMES - LENSES

26. MATERIALS RECORD

DESCRIPTION	DATE	CODE	FEE	PLAN ALLOWANCE	PATIENT RESPONSIBILITY
LENSES: (Excludes low vision aids) NAME OF MFG. LAB					
Single vision		92380			
Bifocal		92381			
Trifocal		92382			
Cataract		92395			
FRAMES: MFG. NAME					
CONTACT LENSES:					
Cosmetic		93296			
20/70 Correction		92314			
EXTRAS: Itemize all additional charges:					
1. Tints Type:					
2. Oversize					
3. Other Type:					
4. Other Type:					
5. Other Type:					
			TOTAL SERVICES		

<p>SERVICES COMPLETED/DELIVERED—PAYMENT REQUESTED</p> <p>I hereby certify that the services as indicated by the date listed have been completed/delivered and the fees submitted are the actual fees charged and intended to be collected for these services. Payment is requested in accordance with the rules and regulations of Health Applications Network.</p> <p>Provider Signature _____</p> <p>Date _____</p>	<p>I accept this claim form and authorize release of information relating hereto. I certify the truth of all personal information contained above and that the services listed above have been completed/delivered. I agree to be responsible for the applicable co-payments, as detailed in my Group Program, for any services indicated as rendered in Item 25 and 26 above. I also agree to be responsible for any and all services which may be rendered but not eligible for coverage under my Group Program.</p> <p>Patient (Parent or Subscriber Signature) _____</p> <p>Date _____</p>
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PROVIDER Signature Required - PATIENT Signature Required