

|                                                                                                                 |                                                                                                                                                                                                                                                                                                                                  |                                                                              |      |                              |                        |          |
|-----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------|------------------------------|------------------------|----------|
| PART A<br>THIS INFORMATION IS TO BE COMPLETED BY THE EMPLOYEE                                                   | <b>PATIENT NAME</b>                                                                                                                                                                                                                                                                                                              |                                                                              |      |                              |                        |          |
|                                                                                                                 | First Name                                                                                                                                                                                                                                                                                                                       | Middle                                                                       | Last |                              |                        |          |
|                                                                                                                 | Street                                                                                                                                                                                                                                                                                                                           |                                                                              |      | City                         | State                  | Zip Code |
|                                                                                                                 | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female                                                                                                                                                                                                                                                             |                                                                              |      | Date of Birth                |                        |          |
|                                                                                                                 | <b>EMPLOYEE NAME</b>                                                                                                                                                                                                                                                                                                             |                                                                              |      |                              |                        |          |
|                                                                                                                 | First Name                                                                                                                                                                                                                                                                                                                       | Middle                                                                       | Last |                              |                        |          |
|                                                                                                                 | Social Security Number                                                                                                                                                                                                                                                                                                           |                                                                              |      | Date of Birth                |                        |          |
|                                                                                                                 | Address (if different from patient)                                                                                                                                                                                                                                                                                              |                                                                              |      |                              |                        |          |
|                                                                                                                 | Street                                                                                                                                                                                                                                                                                                                           |                                                                              |      | City                         | State                  | Zip Code |
|                                                                                                                 | Employer                                                                                                                                                                                                                                                                                                                         | Work Status <input type="checkbox"/> Active <input type="checkbox"/> Retired |      | Effective date of retirement |                        |          |
|                                                                                                                 | Patient's relationship to insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other                                                                                                                                                                    |                                                                              |      |                              |                        |          |
|                                                                                                                 | Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where? _____                                                                                                                                                                                                                                 |                                                                              |      |                              |                        |          |
|                                                                                                                 | Are there any other vision benefits for the: <input type="checkbox"/> employee <input type="checkbox"/> spouse <input type="checkbox"/> patient                                                                                                                                                                                  |                                                                              |      |                              |                        |          |
|                                                                                                                 | If dependent or spouse, please denote full name                                                                                                                                                                                                                                                                                  |                                                                              |      |                              | Date of Birth          |          |
|                                                                                                                 | Other coverage is provided through:<br><input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Employer Sponsored Plan <input type="checkbox"/> Commercial Insurance Company<br><input type="checkbox"/> Health Maintenance Organization (HMO) <input type="checkbox"/> Medicaid <input type="checkbox"/> Other |                                                                              |      |                              |                        |          |
|                                                                                                                 | Please provide information of the other coverage denoted above:                                                                                                                                                                                                                                                                  |                                                                              |      |                              |                        |          |
|                                                                                                                 | Name                                                                                                                                                                                                                                                                                                                             | Street                                                                       | City | State                        | Zip Code               |          |
|                                                                                                                 | Is the spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Spouse's Name                                                                                                                                                                                                                           |                                                                              |      |                              | Social Security Number |          |
|                                                                                                                 | If yes, name and address of spouse's employer:                                                                                                                                                                                                                                                                                   |                                                                              |      |                              |                        |          |
|                                                                                                                 | Name                                                                                                                                                                                                                                                                                                                             | Street                                                                       | City | State                        | Zip Code               |          |
| Was the condition related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                  |                                                                              |      |                              |                        |          |
| Was the condition related to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No              |                                                                                                                                                                                                                                                                                                                                  |                                                                              |      |                              |                        |          |
| If the condition was related to an accident: Date                                                               |                                                                                                                                                                                                                                                                                                                                  |                                                                              |      | Time                         |                        |          |
| Description (how and when) _____                                                                                |                                                                                                                                                                                                                                                                                                                                  |                                                                              |      |                              |                        |          |

To all physicians, other health professionals, all hospitals, and other healthcare institutions: You are authorized to provide AultCare information concerning healthcare, advice, treatment, or supplies provided to the Patient (including that relating to mental illness.) This information will be used for the purpose of evaluating and administering claims for benefits.

AultCare may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.

This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient or Authorized Person Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize payment directly to the named doctor and/or dispenser of vision care for the services described on the next page.

Employee or Authorized Person Signature \_\_\_\_\_ Date \_\_\_\_\_

| PART B<br>THIS INFORMATION IS TO BE COMPLETED BY THE DOCTOR | <b>DOCTOR'S NAME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |          |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------|---------------------|--------|----------------------------|-------------------------------------------------------------------------------------------------|----------|------|-------|------|------|---|---|--|--|--|------|---|---|--|--|--|-------------|--|------|----|------|----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------|--------|--------------------|--|--------------------|--|-------|--|------------------------|
|                                                             | Last                                                                                                                                                                                                                                                                                                                                                                                                                                                        |          | First |                     | Middle |                            | Title <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> O.D. |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
|                                                             | Enter the taxpayer identifying number to be used for 1099 reporting purposes.<br>You are required under authority of law to furnish your taxpayer identifying number. _____                                                                                                                                                                                                                                                                                 |          |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
|                                                             | Street                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          |       | City                |        | State                      |                                                                                                 | Zip Code |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
|                                                             | Phone Number                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |       | Examination Date(s) |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
|                                                             | Has cataract surgery been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Can visual acuity be restored to 20/70 in better eye with conventional eyeglasses? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Does the patient require a prescription change at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                       |          |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
|                                                             | Diagnostic Code(s)                                                                                                                                                                                                                                                                                                                                                                                                                                          |          |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
|                                                             | Indicate diagnosis, nature of disease, injury, or vision disorder _____<br>_____                                                                                                                                                                                                                                                                                                                                                                            |          |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
|                                                             | Indicate the procedure code numbers                                                                                                                                                                                                                                                                                                                                                                                                                         |          |       |                     |        | Visual acuity corrected to |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
|                                                             | <b>Doctor's Prescription</b><br><table border="1"> <thead> <tr> <th colspan="2">Sphere</th> <th>Cylinder</th> <th>Axis</th> <th>Prism</th> <th>Base</th> </tr> </thead> <tbody> <tr> <td>R.E.</td> <td>•</td> <td>•</td> <td></td> <td></td> <td></td> </tr> <tr> <td>L.E.</td> <td>•</td> <td>•</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="2">Reading Add</td> <td>R.E.</td> <td>+•</td> <td>I.E.</td> <td>+•</td> </tr> </tbody> </table> |          |       |                     |        | Sphere                     |                                                                                                 | Cylinder | Axis | Prism | Base | R.E. | • | • |  |  |  | L.E. | • | • |  |  |  | Reading Add |  | R.E. | +• | I.E. | +• | <table border="1"> <thead> <tr> <th>Professional Services</th> <th>Amount</th> </tr> </thead> <tbody> <tr> <td>Examination Charge</td> <td></td> </tr> <tr> <td>Sales Tax (if any)</td> <td></td> </tr> <tr> <td>Total</td> <td></td> </tr> <tr> <td>Amount Paid by Patient</td> <td></td> </tr> </tbody> </table> |  |  | Professional Services | Amount | Examination Charge |  | Sales Tax (if any) |  | Total |  | Amount Paid by Patient |
| Sphere                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Cylinder | Axis  | Prism               | Base   |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
| R.E.                                                        | •                                                                                                                                                                                                                                                                                                                                                                                                                                                           | •        |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
| L.E.                                                        | •                                                                                                                                                                                                                                                                                                                                                                                                                                                           | •        |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
| Reading Add                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | R.E.     | +•    | I.E.                | +•     |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
| Professional Services                                       | Amount                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
| Examination Charge                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |          |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
| Sales Tax (if any)                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |          |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
| Total                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |          |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |
| Amount Paid by Patient                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |          |       |                     |        |                            |                                                                                                 |          |      |       |      |      |   |   |  |  |  |      |   |   |  |  |  |             |  |      |    |      |    |                                                                                                                                                                                                                                                                                                                    |  |  |                       |        |                    |  |                    |  |       |  |                        |

I hereby certify I have performed the services as indicated hereon.

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

In lieu of dispenser completing this section, a laboratory bill can be attached. Dispenser must sign this form and enter amount paid by patient.

|                                                                     |                                                                                                                                                                                                                                                                                                                           |  |                 |                                                                                                                        |                        |                       |      |          |  |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------|------------------------------------------------------------------------------------------------------------------------|------------------------|-----------------------|------|----------|--|
| PART C<br>THIS INFORMATION IS TO BE COMPLETED BY DISPENSER          | <b>DISPENSER'S NAME</b>                                                                                                                                                                                                                                                                                                   |  |                 |                                                                                                                        |                        |                       |      |          |  |
|                                                                     | Last                                                                                                                                                                                                                                                                                                                      |  | First           |                                                                                                                        | Middle                 |                       |      |          |  |
|                                                                     | Enter the taxpayer identifying number to be used for 1099 reporting purposes.<br>You are required under authority of law to furnish your taxpayer identifying number. _____                                                                                                                                               |  |                 |                                                                                                                        |                        |                       |      |          |  |
|                                                                     | Street                                                                                                                                                                                                                                                                                                                    |  |                 | City                                                                                                                   |                        | State                 |      | Zip Code |  |
|                                                                     | Phone Number                                                                                                                                                                                                                                                                                                              |  |                 | Title: <input type="checkbox"/> Optician <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist |                        |                       |      |          |  |
|                                                                     | Materials Supplied<br>Tint # _____ <input type="checkbox"/> Oversized <input type="checkbox"/> Pair <input type="checkbox"/> Glass <input type="checkbox"/> 1/2 Pair <input type="checkbox"/> Plastic <input type="checkbox"/> Other _____                                                                                |  |                 |                                                                                                                        |                        |                       |      |          |  |
|                                                                     | Order Date                                                                                                                                                                                                                                                                                                                |  | Delivery Date   |                                                                                                                        |                        | Professional Services |      | Amount   |  |
|                                                                     | Type of lenses dispensed:<br><input type="checkbox"/> None <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular <input type="checkbox"/> Contacts<br><input type="checkbox"/> Sunglasses <input type="checkbox"/> Other (specify) _____ |  |                 |                                                                                                                        |                        | Lens Charge           |      |          |  |
|                                                                     |                                                                                                                                                                                                                                                                                                                           |  |                 |                                                                                                                        |                        | Frame Charge          |      |          |  |
|                                                                     | Contact Lenses (If contact lenses, please complete.)<br><input type="checkbox"/> Therapeutic <input type="checkbox"/> Non-Therapeutic <input type="checkbox"/> Hard Lenses <input type="checkbox"/> Soft Lenses                                                                                                           |  |                 |                                                                                                                        |                        | OPT                   |      | LENS     |  |
|                                                                     |                                                                                                                                                                                                                                                                                                                           |  |                 |                                                                                                                        |                        | FRM                   |      |          |  |
| Frame Model or<br>Cat. No. & Size                                   |                                                                                                                                                                                                                                                                                                                           |  | Frame MFT. Name |                                                                                                                        | DISP. FEE              |                       | LENS |          |  |
|                                                                     |                                                                                                                                                                                                                                                                                                                           |  |                 |                                                                                                                        |                        |                       | FRM  |          |  |
| I hereby certify I have performed the services as indicated hereon. |                                                                                                                                                                                                                                                                                                                           |  |                 |                                                                                                                        | Sales Tax (if any)     |                       |      |          |  |
|                                                                     |                                                                                                                                                                                                                                                                                                                           |  |                 |                                                                                                                        | Total                  |                       |      |          |  |
| Dispenser's Signature _____ Date _____                              |                                                                                                                                                                                                                                                                                                                           |  |                 |                                                                                                                        | Amount Paid By Patient |                       |      |          |  |



## INSTRUCTIONS FOR FILING A VISION CLAIM

### EMPLOYEE

Complete the Patient Information section. (Part A)

If you wish your benefits are paid directly to your Doctor or Optometrist, sign the bottom of Part A page. If you wish your benefits are paid directly to the provider of materials, sign the bottom of Part A page. A separate form should be submitted for each family member.

Please be sure you have provided the employee's Social Security number.

Send the completed 'Benefit Request Form' directly to AultCare at either PO Box 6910 Canton, OH 44706, via fax at 330-470-4757, or via email at [ancillaryclaimsservices@aultcare.com](mailto:ancillaryclaimsservices@aultcare.com).

### DOCTOR OR OPTOMETRIST

Please complete Part B of this form (examining doctor or optometrist information) and sign your name. Please return the completed form to your patient.

### DISPENSER OF MATERIAL

Please complete Part C of this form (supplier information) and return the completed form to the patient.

**INSURANCE FRAUD WARNING:** Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I acknowledge that AultCare may use and disclose my protected health information, as well as, the protected health information of my family for payment, treatment, and operations. This information may be disclosed to other insurance companies, third party administrators, state and federal agencies, health care providers and other organizations and persons that perform professional, business, or insurance functions for AultCare, as permitted by state and federal law. The information may be used for, but not limited to, processing enrollment applications, risk classifications, detecting or preventing fraud, internal and external audits, claims administration, case management, quality improvement programs, public health reporting, law enforcement investigations, coordination of benefits, medical management programs, and subrogation.