



Administered by
Principal Life
Insurance Company
Des Moines, Iowa

Vision Care Claim
Please mail completed form to:
Principal Life Insurance Company
PO Box 10357
Des Moines, IA 50306-0357
FAX: 866-301-1502

See Page 2 for Claim Filing Instructions.

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, may be guilty of insurance fraud.

Part A – Patient & Employee Information

1. Patient name _____

2. Relationship to employee self wife husband son daughter stepchild foster child male female

3. Sex male female

4. Patient birth date _____ 5. If full-time student, school _____ City _____

6. Employee name (first, middle, last) _____

7. Employee's social security number _____ 8. Plan and ID numbers (printed on employee's ID card)
Plan _____ I.D. _____

9. Employee mailing address _____ Is this a new address?
 yes no

City _____ State _____ ZIP _____

10. Employer (company) name and address _____
City _____ State _____ ZIP _____

11. Is employee single married divorced widowed 12. Spouse's name _____ Spouse's birth date _____

13. Spouse's social security number _____ 14. Is spouse employed? yes no 15. If "yes," give name, address, and telephone number of spouse's employer. _____

16. Is patient covered for vision care by another plan? If "yes," give name of person carrying the other coverage.
 yes no _____

Insurance company or plan name _____ Group number _____

Name and address of carrier _____

17. Was condition related to
A. Patient's employment yes no B. An auto accident yes no

18. I authorize the release of any information necessary to process this claim. Signed (patient or parent if minor) _____ Date _____

Part B – Examining Physician or Optometrist's Information

Indicate diagnosis, nature of disease, injury or vision disorder

If contact lenses, would the visual acuity be corrected to 20/70 in the better eye by use of conventional lenses?

yes no

Report of services or attach itemized bill. (If previous form submitted to this carrier, you need to show only dates and services since last report.)

Date of service	Services rendered	Charges
		\$
		\$
Physician's or optometrist's name		Phone number
		Total charges
Physician's or optometrist's address (street, city, state, ZIP code)		Federal I.D. number or Tax I.D. number
		Amount paid
Physician's or optometrist's signature		Date
		Your patient's account number
		Balance due

Authorization to pay - Sign only if you want benefits paid directly to physician or optometrist.

I authorize payment of vision care benefits to the physician or optometrist described in Part B.

Date

Employee or authorized person's signature

Part C - Supplier Information (To Be Completed by Dispenser of Prescription other than Prescribing Physician)

Type	Date of purchase	Date of delivery to patient	Charges	Supplier name and address (street, city, state, ZIP code)
Lenses				Supplier phone number
Frames				
Contacts				
Tint				
Coating				
Oversizing				
Other				
Type of lenses:			Total charges	Signature of supplier
<input type="checkbox"/> single vision <input type="checkbox"/> bifocal <input type="checkbox"/> trifocal <input type="checkbox"/> lenticular			\$	Date
<input type="checkbox"/> contact lenses <input type="checkbox"/> disposable contact lenses				Patient's account number
number of months supplied: _____				Amount paid
				\$
				Balance due
				\$

Authorization to pay - Sign only if you want benefits paid directly to supplier.

I authorize payment of vision care benefits to the supplier for services described in Part C.

Date

Employee or authorized person's signature

Payment receipt or cash register receipt for prescription attached (See item 5 below.)

Instructions to Employee

- Complete questions 1 through 18 (Part A) on Page 1 and sign and date line 18.
- Have patient's physician or optometrist complete the Examining Physician or Optometrist's Information section (Part B) on Page 2.
- Have patient's supplier (if other than examining physician or optometrist) complete the Supplier Information section (Part C) on Page 2.
- Attach itemized bills for expenses not shown on Page 2. If you want benefits paid directly to the physician or optometrist, sign the Authorization to pay in section (Part B) on Page 2. If you want benefits paid directly to the supplier (if other than examining physician or optometrist), sign the Authorization to pay in section (Part C) on Page 2.
- Attach payment receipt or cash register receipt to claim form if prescription is being filled by someone other than the examining physician or optometrist.