EYES
ON STONEHAVEN

Insurance Claim Form

Provider: Dr. Nameera Chagpar

Patient:____

Plan Number:___________________________________

Certificate/Plan Member Number:__________________

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the Insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider. To disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes of contact lenses, eyeglasses, and vision care.

In the event of fraud, I authorize the provider to provide to any relevant personal information to any relevant organization.

Signature: _____________________ Date:________________________