Colonial Voluntary Benefits

Vision Claim Office
P.O. Box 14389
Baton Rouge, LA 70898-9100
Phone: (888) 400-9304 or (225) 400-9304

Vision Claim Form

Return completed form via fax **(855) 400-9307**, *email* **VisionClaims@ColonialLife.com**, *or mail to the address above.*

The following information is required with your DETAILED RECEIPT for reimbursement:

Subscriber Information			Patient Information		
1. Subscriber social security number or member ID number:			9. Patient relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other		
2. Subscriber name (Last name, First name, MI):			10. Patient name (Last name, First name, MI):		
3. Subscriber's address:			11. Patient's address:		
City:	State:	Zip code:	City:	State:	Zip code:
4. Subscriber birth date: _____/_____/_____ MM DD YY	5. Subscriber gender: ☐ Male ☐ Female		12. Patient birth date: _____/_____/_____ MM DD YY	13. Patient gender: ☐ Male ☐ Female	
6. Email address:	7. Telephone: (_____) _____		14. Email address:	15. Telephone: (_____) _____	
8. Subscriber policy/Group number:			16. Patient status: ☐ Single ☐ Married ☐ Other ☐ Employed ☐ Full-time student ☐ Part-time student		
			17. Is patient covered under a medical plan? ☐ Yes ☐ No Is patient covered under another vision plan? ☐ Yes ☐ No		

Attach copy of receipt and supporting documentation.

Date of Service (MM/DD/YY)	Procedure Code	Diagnosis Code(s)	Amount Billed	Amount Paid
1. _____/_____/_____	_____	_____	$_____.____	$_____.____
2. _____/_____/_____	_____	_____	$_____.____	$_____.____
3. _____/_____/_____	_____	_____	$_____.____	$_____.____
4. _____/_____/_____	_____	_____	$_____.____	$_____.____
5. _____/_____/_____	_____	_____	$_____.____	$_____.____

Provider Information			
Provider federal tax ID or NP ID:	Eye care professional name:		
Facility name:	Facility address:		
City:	State:	Zip:	Telephone: (_____) _____

Patient's or authorized person's signature:
I authorize the release of any medical or other information necessary to process this claim.

Signature: _____ *Print name:* _____ *Date:* _____

NOTE: Missing or inaccurate information on claim forms will cause delays in claim processing. *Copy of detailed receipt must be included.*

CL-1208-NY (5-18)