Frontier Eye Care
and Eyewear Gallery

Insurance Information

At Frontier Eye Care, we strive to make your life easier, including filing insurance claims on your behalf. Please understand, however, that we may not have a contract with your insurance company. Also, failure to present your insurance information at this time will limit our ability to file a claim on your behalf. In such cases, we simply require payment at the time services are rendered, and will provide you with an itemized receipt that you can personally file with your insurance company. And, of course, even if we file a claim on your behalf, you are still responsible for copayments, deductibles, and/or denied claims. Providing the information requested below will allow us to file claims on your behalf today or as the need arises in the future. Thank you! Please let us know if you have any questions.

Patient Name: _____ Today's Date: _____/_____/_____
Birth Date: _____/_____/_____ Social Security #:_____/_____/_____ ☐ Male ☐ Female

VISION INSURANCE

Vision Insurance Company: ☐ None ☐ VSP ☐ EyeMed ☐ T-19 (Under 21) ☐ Other: _____
Insurance ID Number: _____ Group #: _____
Insured's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____
Insured Name (if not patient): _____ Insured Birth Date: _____/_____/_____
Social Security #:_____/_____/_____ Insured Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

PRIMARY MEDICAL INSURANCE

Medical Insurance Company: ☐ None ☐ Medicare ☐ Medicaid ☐ BC/BS ☐ Other: _____
Insurance ID Number: _____ Group #: _____
Insured's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____
Insured Name (if not patient): _____ Insured Birth Date: _____/_____/_____
Social Security #:_____/_____/_____ Insured Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

ADDITIONAL (SUPPLEMENTAL) MEDICAL INSURANCE

Supplemental Insurance Company: ☐ None ☐ Medicare ☐ Medicaid ☐ BC/BS ☐ Other: _____
Insurance ID Number: _____ Group #: _____
Insured's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____
Insured Name (if not patient): _____ Insured Birth Date: _____/_____/_____
Social Security #:_____/_____/_____ Insured Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

INSURANCE AUTHORIZATION

I request that payment of authorized Medicare (or other insurance) benefits be made or on my behalf to Frontier Eye Care for any services furnished to me. I authorize any holder of medical information about me to release to the CMS and its agents, or other medical insurance and their agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated on approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I, the patient, am responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier (or my other insurance company).

Signature (Insured Patient or Guardian):_____ Date _____