Principal Financial Group

Administered by
Principal Life
Insurance Company
Des Moines, Iowa

Vision Care Claim

Please mail completed form to:
Principal Life Insurance Company
PO Box 39710
Colorado Springs, CO 80949-3910
FAX 719-548-4001

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

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? ☐ yes ☐ no

If "yes," give name of person carrying the other coverage.

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

Print

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.

▶ Employee or authorized person's signature | Date

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
Lenses			
Frames			
Contacts			
Tint			
Coating			
Oversizing			
Other			

Supplier name and address (street, city, state, ZIP code)

Supplier phone number

Federal I.D. number or tax I.D. number

Type of lenses:

☐ single vision ☐ bifocal ☐ trifocal

☐ lenticular ☐ contact lenses

☐ disposable contact lenses

number of months supplied: _____

Total charges $

▶ Signature of supplier | Date

Patient's account number

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.

▶ Employee or authorized person's signature | Date

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

Instructions to Employee

(1) Complete questions 1 through 18 (**Part A**) on Page 1 and sign and date line 18.

(2) Have patient's physician or optometrist complete the **Examining Physician or Optometrist's Information** section (**Part B**) on Page 2.

(3) Have patient's supplier (if other than examining physician or optometrist) complete the **Supplier Information** section (**Part C**) on Page 2.

(4) 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.

(5) Attach payment receipt or cash register receipt to claim form if prescription is being filled by someone other than the examining physician or optometrist.