54 Rushworth St., San Fernando
Tel: 657-3812 / Fax: 653-4850

1st Floor, King's Court
44 Park St., Port of Spain
Tel: 627-0473
email:
claims@mediservinternational.com

VISUAL IMPAIRMENT CLAIM FORM
PRINCIPAL'S STATEMENT

(Note: ALL questions MUST be answered for every claim.
NA = Not Applicable)

Principal's RAN: _____ Plan Code: _____ Group Name: _____ Group Number: _____

Principal's Present Coverage $_____ Original Commencement Date _____ Upgrade/Downgrade Date _____ Claim No. _____

1. Principal's Name _____ Date of Birth: _____ Sex: Female ☐ Male ☐
2. Name of Patient _____ Date of Birth: _____ Sex: Female ☐ Male ☐
3. Relationship of Patient to Principal: Self ☐ Spouse ☐ Child ☐ Other ☐ (Explain) _____
4. Name of Attending Ophthalmologist / Optometrist _____
5. Has the claimant familiarized him/herself with the terms and conditions of the contract for this medical plan? Yes ☐ No. ☐
6. When did symptoms of this illness occur? ⇒ ⇒ ⇒ D /M /Y. NA ☐
7. Was treatment necessary because the patient was injured or poisoned? ⇒ ⇒ ⇒ Yes. ☐ No. ☐
8. If patient was injured or poisoned, state the **Date**, **Time** and **How** the incident occurred _____ NA ☐
9. Did patient voluntarily participate in an activity that targeted the patient for abuse or endangerment? ⇒ Yes. ☐ No. ☐ NA ☐
10. Is patient entitled to Workmen Compensation or coverage under any other medical plan? ⇒ ⇒ Yes. ☐ No ☐
11. If you gave 'Yes' to question 10 above, give name of Company. _____ NA ☐
12. If you gave 'Yes' to question 10 above, has patient made any claim for the relevant benefits? ⇒ Yes. ☐ No. ☐ NA ☐
13. GEMS credit consumed? $_____ D /M /Y. Repaid? $_____ D /M /Y. Balance Unpaid? $_____ NA ☐
14. Check all your receipts submitted for this claim and in the spaces provided below please write your total expenses for each category.

A) Examination? $_____ D) _____? $_____ G) Discount
B) Frame? $_____ E) _____? $_____ (If Applicable)
C) Lens? $_____ F) _____? $_____ $ _____

H) What is the discounted value of the expenses supporting your claim for which you have submitted the receipts listed above? $_____

I hereby certify that the forgoing answers are true and correct to the best of my knowledge and hereby authorize all doctors or other persons who treated me and all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to MEDISERV INTERNATIONAL Ltd. or its assigns (the Company). I also understand that only original documents are valid in support of my claim and that once submitted, all documents associated with the expense and other relevant circumstances associated with the loss, becomes the property of the Company.

Date _____ Principal's Signature X _____ Patient's Signature (if over 18yrs) X _____

APPLICATION FOR ASSIGNMENT OF COVERAGE BENEFITS **NA** ☐

I hereby authorize MEDISERV INTERNATIONAL Ltd. to pay to _____ whatever benefits to which I may be entitled with respect to the services rendered to the named patient from _____ 20____ to _____ 20____
All Charges that are not covered by the Medical Plan shall be borne by me.

_____ X _____ **NA** ☐
Date Principal's Signature

FOR OFFICIAL USE ONLY

_____ X _____ _____
Date Received Group Administrator's Signature Recipient's Name (PRINT) Title

Be certain ALL questions are answered and ALL information requested is furnished.

The Attending Ophthalmologist/Optometrist statement on the reverse side MUST be completed and furnished

PLEASE COMPLETE THIS CLAIM FORM AND RETURN TO YOUR PATIENT

VISUAL IMPAIRMENT CLAIM FORM

OPTOMETRIST / OPHTHALMOLOGIST

Name ……

Address ……

Tel. No. ……..

Was treatment The Result Of Accident? Yes ☐ No ☐ Occupational Injury Yes ☐ No ☐

I hereby certify that the services listed have been Performed ☐ Planned ☐

Signature of Ophthalmologist/Optometrist _____ Date _____

PATIENT

Name ……

Address ……

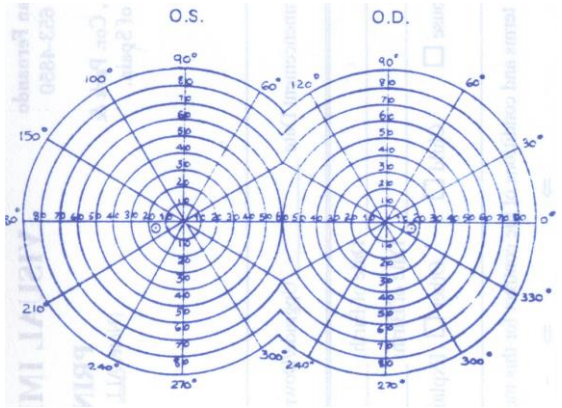
Tel. No…..…… Patient's Birth date: M …….D ……Y……

Male. ☐ Female ☐ Single ☐ Married ☐

Relationship To Principal: ……

When did patient first consult you for this condition? ……..……

EXAMINATION AND TREATMENT RECORD



Snellen	Percent Central Vision Efficiency	Percent Loss of Central Vision
20/20	100	0
20/25	95	5
20/32	90	10
20/40	85	15
20/50	75	25
20/64	65	35
20/80	60	40
20/100	50	50
20/125	40	60
20/160	30	70
20/200	20	80
20/300	15	85
20/400	10	90
20/800	5	95

DESCRIPTION OF SERVICE	FEE	
CARRIER USE ONLY		

(A) If fields of vision are contracted, show contraction on chart.

(B) What was vision at last observation ? With Glasses ……O.D ……O.S…….DAY…….MTH……..20……..
Without Glasses……O.D ……O.S…….DAY…….MTH……..20……..

(C) Date corrected vision was irrecoverably reduced
To 20/200 or less in the better eye ……O.D…….O.S…….DAY…….MTH……..20……..

(D) Vision can be restored in whole or in part by ……...O.D. LENSES ☐ TREATMENT ☐ OPERATION ☐ NOT RESTORABLE ☐
O.S. LENSES ☐ TREATMENT ☐ OPERATION ☐ NOT RESTORABLE ☐

_____RE

MARKS

JULY 2002