

SECTION A: CLAIMANT INFORMATION

 Patient Name

 Date of Birth

Sex

 Male Female

 Patient's Physical Address

Patient Insured Status

 Self Dependant

 Subscriber Name

 Member ID

 Group Policy Number

 Group Name

Claimant's Authorization

I authorize One Health Cayman to obtain medical records from any medical service provider, insurer, employer, or other source deemed necessary to settle this claim.

Payment Assignment

I authorize One Health Cayman to pay the proceeds of this claim to the undersigned Vision Care Provider(s).

 Signature

 Date

 Signature

 Date

SECTION B: VISION SERVICES

 Optician Name

 Phone Number

 Optician Address

Services Rendered/Items Supplied	Fees	USD	KYD
Frame <input type="text"/>			
Lenses <input type="checkbox"/> None <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Lenticular <input type="checkbox"/> Other <input type="text"/>			
Contact Lenses <input type="checkbox"/> None <input type="checkbox"/> Therapeutic <input type="checkbox"/> None-Therapeutic <input type="checkbox"/> Hard Lenses <input type="checkbox"/> Soft Lenses			
Other <input type="text"/>			
TOTAL FEES			
PAID BY PATIENT			
BALANCE DUE			

BANK DETAILS: If you would like to be reimbursed by EFT direct deposit, please provide your Cayman banking details.

 Bank Name

 Account Name

 Account Number

 Account Currency

 Account Type

I hereby certify that this is a true statement of treatment and services rendered

 Signature of Optician or Member

 Date

 Once complete, please email this form and itemized receipts to claims@onehealth.ky