PLEASE GIVE THIS FORM TO THE PANEL PROVIDER

Northwest Benefit Network — Vision Plan

Eligibility Authorization #

Plan # NK

Name of Group **North Kitsap School District**

FIRST-PAIR ☐ SECOND PAIR ☐

Local Union

Employee's Social Security No.

Name of Employer

Employee's Name (First) (Last)

Employee's Date of Birth

Spouse's Date of Birth

Employee's Address and Phone — City — State — Zip Code — Home Phone #

Claim is for: ☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other

NAME OF PATIENT ***Please See Back of First Page.** (First) (Last)

☐ MALE ☐ FEMALE

DATE OF BIRTH

IS PATIENT A FULL-TIME STUDENT? ☐ YES ☐ NO

IF YES, NAME OF SCHOOL CURRENTLY ATTENDING

For________ Quarter of 20____

STUDENT IS UNMARRIED & DEPENDS UPON ME FOR SUPPORT ☐ YES ☐ NO

* Please see reverse side of this form for Dependent Child Eligibility Questionnaire.

SPOUSE'S NAME

NAME AND ADDRESS OF SPOUSE'S EMPLOYER

SPOUSE'S SOCIAL SECURITY NUMBER

DOES SPOUSE HAVE OTHER VISION INSURANCE? ☐ YES ☐ NO

NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THESE SERVICES

Policy Number

Was Vision Care required because of an injury? ☐ YES ☐ NO If yes, complete questions below.

WAS INJURY CAUSED BY YOUR WORK? ☐ YES ☐ NO

HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKERS COMPENSATION CARRIER? ☐ YES ☐ NO

IS VISION EXAMINATION REQUIRED AS A CONDITION OF YOUR EMPLOYMENT? ☐ YES ☐ NO

The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize any person or institution rendering care to furnish and disclose all facts concerning this claim. I agree that, if my employer does not provide coverage for the expenses incurred or I am not eligible for benefits, I will be responsible for payment of all charges.

DATE

EMPLOYEE'S SIGNATURE

*** * Note To Providers** **The Lower Portion of This Claim Must Be Fully Completed By the Attending Panel Provider**

*** * If You Are NOT An NBN Panel Provider, Please Provide The Patient With An Itemized Bill. You Do Not Need To Complete This Claim Form.**

Name of Provider To Be Paid

DEGREE

Tax ID Number

Address

Provider's NBN Number

City, State Zip Code

Date Services Began

Date Services Completed

I HEREBY CERTIFY THAT I PERSONALLY PERFORMED THE PROFESSIONAL SERVICES AND HAVE BILLED NBN NO MORE THAN MY USUAL AND CUSTOMARY FEE

Signature of Attending Provider

EXAMINATION	EXAM FEE	LENS	LENS COST
Comprehensive ☐ Intermediate ☐ Limited ☐		Single Vision ☐ Bifocal ☐ Trifocal ☐ Lenticular ☐ Progressive ☐ GLASS ☐ PLASTIC ☐	
MATERIALS SERVICES	**DISPENSING FEE**	**CONTACT LENS**	**CONTACTS COST**
Did you Prescribe? Yes ☐ No ☐		Elective Contact Lenses ☐ Subnormal Vision Aid PAIR ☐ Subnormal Vision RIGHT LENS ☐ Subnormal Vision LEFT LENS ☐	
MATERIALS SERVICES		**FRAMES**	**FRAMES COST**
Did you Dispense? Yes ☐ No ☐		New Frame ☐ Patient's Frame ☐ NAME OF FRAME/MANUFACTURER	

Please send fully completed and **signed** NBN copy to:

Northwest Benefit Network
2323 Eastlake Avenue East
Seattle, WA 98102
(206) 726-3278

Tax Rate %

Total
$

Provider, please retain the Doctor Copy for your records.
Lab Copy should only be sent to an NBN Approved Lab.

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NBN COPY