Vision Claim Form

Varflex Corporation

Subscriber (Employee) Name:

Social Security Number: Birthdate: / /

Address:

Street: _____

City: _____ State: _____ ZIP: _____

Patient Name:

Social Security Number: Birthdate: / /

Relationship to Subscriber:

❑ Self ❑ Spouse ❑ Child

❑ Other _____

Services

Date of Service	Description of Service	Left Eye	Right Eye	Insurance Payment	Discount	Final Fee Due

Remarks:

Total:

Amount Paid:

Balance Due:

Please issue payment to: ❑ Provider ❑ Subscriber (Employee)

Submit Claims to:
GMR Associates
2300 Buffalo Rd., 600C
Rochester, NY 14624

Phone: 585-429-1330 x133
Fax: 585-426-6981
jlonthair@gmr-usa.com

Provider Information

Provider / Facility Name:

Contact Information:

Street: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Tax ID #: _____

Certification

I hereby certify the services listed above have been performed on the specified dates. I authorize the release of my information pertaining to these services. I understand and acknowledge the charges that are due and am responsible for payments. I certify this statement to be true and complete to the best of my knowledge.

Provider Signature *Date*

Subscriber / Patient Signature *Date*