[redacted]

Submit claim to Medical Mutual using the address on the member's ID card.

MEDICAL MUTUAL®

VISION CARE

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE ☐ FEMALE ☐	6. SUBSCRIBER'S IDENTIFICATION NO.
	7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8. SUBSCRIBER'S GROUP NO. **RECIPROCITY** N
9. OTHER HEALTH INSURANCE (ENTER NAME AND ADDRESS OF OTHER INSURANCE, POLICY HOLDER OF OTHER INSURANCE AND POLICY HOLDER'S EMPLOYER.	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ☐ NO ☐ B. ACCIDENT AUTO ☐ OTHER ☐	11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) 11A. CHAMPUS SPONSOR'S STATUS ☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED — BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. SIGNED DATE		

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ◀	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES	16A. IF EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G., PUBLIC HEALTH AGENCY)			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21. NUMBER AND NAME OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN OFFICE)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES	

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1,2,3 ETC. OR DX CODE

1.
2.
3.
4.

B.
EPSDT YES ☐ NO ☐
FAMILY PLANNING YES ☐ NO ☐
PRIOR AUTHORIZATION NO.

24. A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G T.O.S	H
									M
									M
									M

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PARTY THEREOF)	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES ☐ NO ☐	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
	30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN, SUPPLIER AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.		
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER ID NO.			

Signature of Physician (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally rendered by me or my employee under my personal direction.

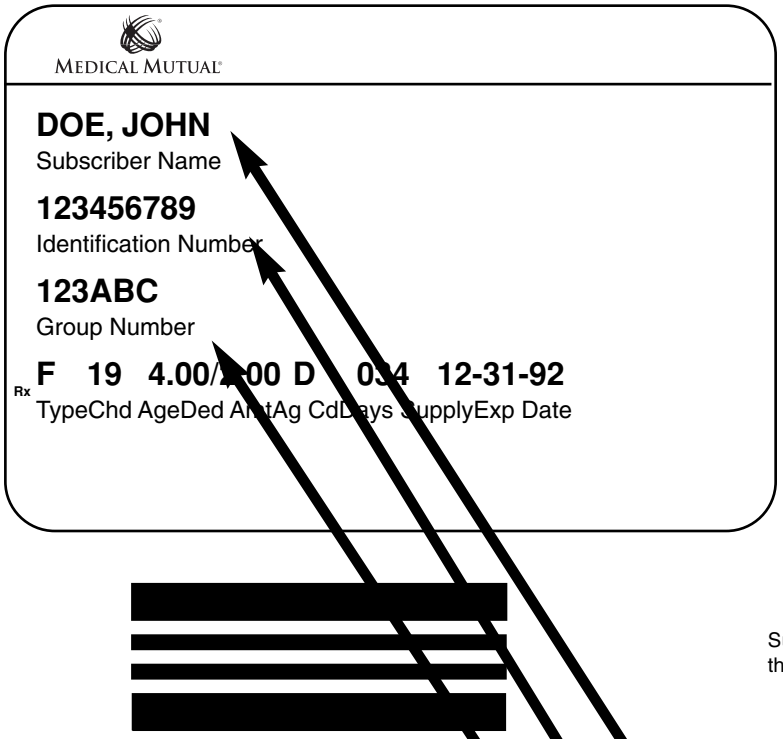
NOTICE: This is to certify that the foregoing information is true, accurate and complete.

PLACE OF SERVICE CODES:

1 – Inpatient Hospital
2 – Outpatient Hospital
3 – Doctor's Office
4 – Patient's Home
5 – Day Care Facility (PSY)
6 – Night Care Facility (PSY)
7 – Nursing Home
8 – Skilled Nursing Facility
9 – Ambulance
0 – Other Locations
A – Independent Laboratory
B – Ambulatory Surgical Center
C – Residential Treatment Center
D – Specialized Treatment Facility
E – Comprehensive Outpatient Rehabilitation Facility
F – Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

1 – Medical Care
2 – Surgery
3 – Consultation (Inpatient only)
4 – Diagnostic X-Ray
5 – Diagnostic Laboratory
6 – Radiation Therapy
7 – Anesthesia
8 – Assistant at Surgery
9 – Other Medical Service
0 – Blood or Packed Red Cells
A – Used DME
F – Ambulatory Surgical Center
H – Hospice
L – Renal Supplies in the Home
M – Alternate Payment for Maintenance Dialysis
N – Kidney Donor
V – Pneumococcal Vaccine
Y – Second Opinion on Elective Surgery
Z – Third Opinion on Elective Surgery



Submit claim to Medical Mutual using the address on the member's ID card.

MEDICAL MUTUAL

VISION CARE

PATIENT AND INSURED (SUBSCRIBER) INFORMATION		
1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. SUBSCRIBER'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE ☐ ☐ FEMALE	6. SUBSCRIBER'S IDENTIFICATION NO.
	7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER ☐ ☐ ☐ ☐	8. SUBSCRIBER'S GROUP NO. **RECIPROCITY** N
9. OTHER HEALTH INSURANCE (ENTER NAME AND ADDRESS OF OTHER INSURANCE, POLICY HOLDER OF OTHER INSURANCE AND POLICY HOLDER'S EMPLOYER.	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ☐ ☐ NO B. ACCIDENT AUTO ☐ ☐ OTHER	11. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE) 11A. CHAMPUS SPONSOR'S STATUS ☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED BRANCH OF SERVICE