



**SVS VISION
PREPAID VISION CARE PROGRAM**

**INSTRUCTIONS FOR SUBMITTING THE APPLICATION FOR BENEFITS
PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM**

GENERAL INFORMATION

- FILL OUT A SEPARATE CLAIM FORM FOR EACH ELIGIBLE FAMILY MEMBER.
- ATTACH EACH MEMBER'S PAID ITEMIZED RECEIPTS TO THE COMPLETED FORM.
(CASH REGISTER RECEIPTS, CANCELLED CHECKS, MONEY ORDER RECEIPTS, AND PERSONAL ITEMIZATIONS ARE NOT ACCEPTABLE)
- EACH ITEMIZED BILLING OR PAID RECEIPT MUST CONTAIN:
 1. NAME AND ADDRESS OF PROVIDER (DOCTOR OR PERSON PROVIDING THE VISION CARE).
 2. EMPLOYEE SOCIAL SECURITY NUMBER.
 3. PATIENT'S FULL NAME.
 4. EXACT DATE (MONTH, DAY, YEAR) EACH SERVICE WAS PERFORMED.
 5. TYPE OF SERVICE PERFORMED (USING PROCEDURE CODES BELOW).
 6. AMOUNT CHARGED FOR EACH INDIVIDUAL SERVICE PERFORMED.
- MAKE ANY NEEDED COPIES OF ITEMIZED BILLINGS OR PAID RECEIPTS FOR YOUR FILES BEFORE SUBMITTING THE ORIGINALS. ALL MATERIALS SUBMITTED WILL BE RETAINED FOR OUR FILES.
- IF THE DOCTOR/PERSON WHO PROVIDED THE VISION CARE SERVICES COMPLETES THE CLAIM FOR YOU, PLEASE ADVISE HIM/HER TO USE THE PROCEDURE CODE STRUCTURE ON THIS FORM. PLEASE ASK YOUR PROVIDER TO SUPPLY THEIR LICENSE NUMBER AND SPECIALITY IN THE SPACES PROVIDED AT THE BOTTOM OF THE CLAIM FORM.
- MAIL TO: SVS Vision, Prepaid Vision Care Program
 PO Box 464
 Mt. Clemens, MI 48046-0464

PROCEDURE CODES

USE THE CODE(S) THAT BEST DESCRIBE SERVICES PERFORMED.

VISION EXAM		9300		
FRAMES		6704		
LENSES	SV GLASS	6740	SV PLASTIC	6749
	BIFOCALS GLASS	6710	BIFOCALS PLASTIC	6720
	TRIFOCALS GLASS	6770	TRIFOCALS PLASTIC	6778
CONTACT LENSES	SOFT LENSES	6730	HARD LENSES	6731
SPECIAL LENSES	ASPHERIC, MYODISC, LENTICULAR, PRISM, SLAB-OFF PRISM, BASE CURVE AND CATARACT LENSES FOR OTHER THAN APHAKIC CONDITIONS			6800
TINTS	ROSE 1 OR 2 OR EQUIVALENT			6786
	GREATER THAN ROSE 2 OR EQUIVALENT			6787